West Alabama Mental Health Center

Organizational Strategic Plan

FY 2008-2011

- **Performance Improvement**
- **Management of Information**
- **Substance Abuse – CQI**
- **Health and Safety**
- **Human Resources**
- **Program Service Descriptions**

Approved this 29th day of September, 2009

Presiding Officer of the Board
West Alabama Mental Health Center

Patricia Perry Moore, M.S.
Executive Director
West Alabama Mental Health Center

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Annual Approval Page

Organizational Strategic Plan

- Performance Improvement
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- Program Service Descriptions

FY 2008 – 2011

Approved this 27th day of November, 2007

Charles C. Hall

Presiding Officer of the Board
West Alabama Mental Health Center

Kelley Parris-Barnes
Executive Director
West Alabama Mental Health Center

West Alabama Mental Health Board, Inc.
Strategic Plan for FY 2008-2011

Organizational History & Summary of Past Activities

In 1965, with the passage of Act 881, the State of Alabama began development of a comprehensive mental health program. Act 881 created the Alabama Department of Mental Health as well as a steering committee to investigate the establishment of regional mental health centers to provide mental health services to the citizens of Alabama. They divided the state into nineteen areas called Catchment areas. The area now recognized as West Alabama Mental Health's coverage area, Choctaw, Greene, Hale, Marengo, and Sumter counties and assigned the designation of the M-10 Catchment Area. The 1967 Alabama Legislature passed Act 310, which established the groundwork for the development of a system of comprehensive community mental health boards and programs. Act 310 allowed counties and municipalities to form public non-profit boards with the authority to implement programs, operate facilities, and maintain equipment in an effort to combat any or all forms of mental or emotional illness or debility.

The West Alabama Mental Health Board was incorporated in 1969. The Board began plans for the development of a central mental health center and satellite offices in each of the five counties designated as the M-10 Catchment area. The early days of the Board and the mental health agency were exciting days with a great sense of anticipation and community energy to establish programs for mental and emotional illness, alcoholism/drug addiction, mental retardation, and epilepsy. Although they acquired the services of an Executive Director in 1970, volunteers played a major role in the development of the first phase of mental health care and treatment in the M-10 Catchment area. Education of the community was a top priority in the early days of mental health. Volunteers trained in weekly sessions and served as consultants to the community concerning mental health issues. During this time, West Alabama Mental Health Center concentrated on the prevention of mental illness and substance abuse and provided programs upon request to the community. Monitors were established to assure a satisfactory quantity and quality of services to aid in the expansion of a rapidly growing agency. One of the first programs for the seriously mental ill was an outreach program which provided medication to individuals diagnosed with schizophrenia and other significant mental illnesses.

Surveys in 1971 indicated that mental health services failed to reach thirteen out of fourteen seriously mentally ill individuals. At the same time, the Alabama Department of Mental Health and Mental Retardation (DMH/MR) began to emphasize the need for a full range of services in local communities. To support

these programs, the West Alabama Mental Health Board, Inc. received an eight year 2.5 million dollar federal grant to develop services. This grant allowed the Board to develop and provide: inpatient, outpatient, partial hospitalization, 24-hour emergency services, consultation, education, and indigent drug services. The population of the five county area was estimated at approximately 82,920 at that time.

1972 brought the needed expansion of services to all five counties in the M-10 Catchment area. There were four full-time employees, six part-time employees, and two hundred and fifty volunteers working to develop these programs. West Alabama Mental Health served 378 consumers in 1972. At the end of the year, the number of employees had grown to thirty-two and partial hospitalization programs had begun. An Advisory Board was established for operational support of mental health.

The agency continued to grow throughout the seventies as programs for substance abuse and mental retardation were developed and mental illness programs experienced an expansion in services. A detoxification unit for substance abuse was established at the Sumter County Hospital in 1973. This led to the eventual development of a substance abuse residential center, Alpha House, in York, Alabama, located in Sumter County. Programs for adults with mental retardation and services for children with severe handicaps or developmental disabilities were offered in all five counties. An inter-agency council was formed to coordinate all services in the five county area. At this time most programs were housed in rental property such as older residential or business dwellings. In 1978, the City of Demopolis leased the Board land and funds were obtained to build a new building, which would eventually house the administrative offices of the WAMHC as well as the clinical programs for Marengo County. Federal legislation in 1978 required public schools to provide services and educational opportunities for handicapped children. Because of this, the Board began to phase out services to developmentally disabled children in all five counties.

By the late 1970's and early 1980's, Board programs for mental illness, substance abuse, and mental retardation were well established in all five counties. The Board had offices in all five counties, which provided outpatient, partial hospitalization/day treatment programs, case management, and prevention/education programs services. A reference library had been established at the administrative office and services were being delivered in an effective and efficient manner. However, the Board, and the programs offered by the Board, was about to undergo a dramatic change.

Funding problems, the loss of the federal grant dollars and state funding cuts, created an administrative crises resulting in the closing of several satellite offices

and a near decertification of the center by the Alabama Department of Mental Health and Mental Retardation. During this period of adjustment, the mental health center and Board were stabilized through the efforts of Board President W. H. Billy Smith; and the hiring of Richard Craig, Ph.D. as Center Director.

The Board began the long process of re-establishing satellite offices in each of the five counties and regaining the trust and confidence of the citizens of those counties. In 1985, offices operational in each county. However, it was not until 1993 that all basic mental illness programs, outpatient, 24-hour emergency, partial hospital/day treatment, prevention/education, and other services were offered in all five counties. Case management services for the seriously mentally ill were implemented in all five counties in 1987. However, funding problems through DMH/MR forced the closing of the Board's substance abuse residential facility, Alpha House, in June 1990. Funding for this facility was transferred to another community mental health center and later appropriated to a freestanding program in another part of the state. This closing has essentially resulted in a tremendous geographical gap in the provision of residential substance services to citizens in west Alabama.

Planning efforts between DMH/MR and the Alabama Council of Community Mental Health Boards led to capital construction of a number of Board operated facilities. These facilities are leased to the Board by DMH/MR and will eventually revert to Board ownership in the future. This two-phase bond issue project resulted in outpatient/day treatment facilities being built in Choctaw and Hale counties, mental retardation classroom/day habilitation training facilities in Choctaw and Marengo counties, and a mental illness residential facility in Marengo County.

Another joint project between DMH/MR and the Alabama Council of Community Mental Health Boards resulted in the transfer in of additional state funds to community mental health centers including West Alabama Mental Health Center. This project called Bed Reduction Phase I&II provided funding to the Board to open and operate the Springhill Home residential facility. In 1996, DMH/MR transferred monitoring and contractual responsibility of the State's Non-Institutional Care Program to community providers. This expanded the Board's Non-Institutional Care Program with the addition of two foster homes located in Greene County and monitoring and placement responsibilities for numerous nursing beds in the five county area.

Community surveys and requests form other agencies indicated the need for expanded children's services in the five counties. In 1996-97 a proposal was presented and funded by DMH/MR to begin an innovative children's outreach program. This marked the first expansion of children's services in the history of

the mental health center. This program, the Mobile Access to Children's Services (MACS), has now been implemented in all five counties and has been well received. The same year saw the addition of the agency's first full-time outpatient counselor for children and adolescents and the addition of a consulting psychiatrist for children and adolescents. In an effort to link with other agencies or programs in the area, the Child and Adolescent Program of the Board is providing services to a Department of Youth Services residential facility for adolescent females in Hale County.

The Board was offered and accepted an opportunity to move from DMH/MR Mental Retardation Region III to Region II in 1996. The Regional offices have resulted in a greater inconsistency of DMH/MR standards being interpreted across the state and the outmoded addition of a layer of bureaucracy. This had a negative effect on program development for mental retardation. Case management services for mental retardation have been implemented for all five counties, and supportive employment opportunities have been developed for area residents.

Substance Abuse services initially focused on individual outpatient evaluation and counseling following the closing of the Alpha House. In 1992 funding was made available on a per capita basis to develop intensive outpatient programs (IOP) for the treatment of substance abuse problems. An IOP was developed at the main center office in Demopolis for this purpose. Until 1998 this program provided the only local resource for substance abuse treatment in the five county area. With the reinstatement of lost funding, acquired through DMH/MR the help of the Cahaba Mental Health Board and Alabama Council, additional staff were hired for the Substance Abuse Program and efforts continue to establish IOP's in each of the five counties. The Prevention Program has been energized and expanded with a full-time and part-time staff member.

Administratively, the Board has allowed the current administration great flexibility in the reorganization of the center. In 1997 the Board supported the addition of a full-time administrative clinical director and the creation of administrative directors for each of the programs operated by the Board. They have also been supportive of various operational initiatives and management training initiatives. The Board also supported the addition of a full-time human resource and quality assurance staff member acting as the identified consumer and consumer rights protection and advocacy staff person.

During 1999 the leaders of WAMHC began a management team system composed of the Performance Improvement Committee, which acts as the leadership committee and various other supportive committees to insure input from all areas and levels of staffing in the agency. This has proved extremely useful in the management of the organization, sharing of information within the

organization, and promoting a monitoring system for management purposes. Numerous procedures were implemented during the year to formalize this process, including: the development and adoption of a Strategic Plan to guide the organization, a Performance Improvement Plan to direct monitoring activities, a Management of Information Plan to formalize the use of information obtained through monitoring and other activities. Although there is much work to be done on the process, there was much accomplished during the past year.

As the year progressed, it became clear that the Center was losing money. Through the committee structure a cost analysis of several programs and services revealed losses in day treatment/partial hospital programs, child and adolescent programs, substance abuse, and CRP programs. This process allowed the Performance Improvement Committee to take corrective action concerning these losses. Eventually this process led to the closing of mental illness day treatment/partial hospital programs in Choctaw County, Greene County, Hale County, Sumter County, and Springhill Home. Most of the financial deficit in these programs was due to denial of payment by Medicare because of a lack of medical necessity". Prior to closing the programs consultants were hired to evaluate the programs and recommend changes so that reimbursement could be obtained. However, these programs continued to receive Medicare denials and cash reserves were depleted resulting in the recommendation to the Board to close the programs.

FY 2000 was a year of stabilization for WAMHC highlighted by the restructuring of the administrative lines of authority and appointment of Joyce Weiss as Associate Director for Clinical Services and Kelley Parris-Barnes as Associate Director for Administration. Great strides were made in the use of data produced by monitoring key indicators in the management of the organization. Supporters of WAMHC were saddened by the death of W. H. Billy Smith. In honor of Mr. Smith, the Board voted unanimously to name and dedicates the Administrative and Outpatient Services building in Demopolis in his memory. At the same time, the Board also voted to name and dedicate the Greene County facility after Ms. Esther Crawford, a past President of the Board and long time supporter of mental health issues in the area.

FY 2001 brought many changes to the organization. Due to funding issues, Res-Care, Inc. declined the opportunity to contract through WAMHC Board, Inc. for mental retardation residential services. After negotiations with DMH/MR, the Board agreed to assume responsibility for the mental retardation residential services. This added approximately sixty-five employees to the staff of WAMHC and more than $700,000 to the Board's operating budget. The Board also submitted a proposal to participate in the Wyatt settlement by shifting the focus of the Springhill Home to a "Specialized Behavioral" residential facility and take individuals out of DMH/MR operated inpatient facilities statewide. With the

approval of the Board's proposal, Springhill Home had residential funding from DMH/MR for the first time. The funding allowed the Board to shift "census reduction" funding to open five supportive apartments in Demopolis.

The Board voted to review and update the agency by-laws. In cooperation with the Board's attorney, Mr. Hugh Lloyd, the by-laws were reviewed and an Amendment and Restatement of the by-laws was presented to the Board. Before approval of the Amendment and Restatement of the by-laws, the Board passed a resolution to seek an Attorneys General opinion concerning Act 310 and the need or requirement for an executive committee. Board training was offered to members and as a result the Board became more active than in previous years. Board members and staff were saddened by the death of Mr. Samuel Columbus Tooson; Hale County Board Member for more than twenty-one years. The Board dedicated the activity room at the Hale County office in memory of Mr. Tooson on July 31, 2003.

With a split decision, the Board voted to allow the Executive Director to reorganize clinical services by service area promoting Patricia Moore to Associate Director for Mental Retardation and Outreach Services. (Case Management, Residential Services, and Day Programs). Joyce Weiss remained Associate Director for Outpatient Services (Mental Illness, Child and Adolescent, and Substance Abuse Services) and area where the Board should have future expansion of services over the next few years. This reorganization allowed the administration to address projected deficits in the mental retardation residential program and cash flow problems.

During FY 2002 the Board adopted its new by-laws eliminating the executive committee based on the Attorneys General opinion. Behavioral Health Promotion moved into an office in downtown Demopolis after securing a grant to help finance the move. The Board submitted a federal mental health initiative grant in collaboration with the DMH/MR and Cahaba Mental Health Center. If approved, this grant called the Alabama Rural Communities of Hope (ARCH) project, will allow for the expansion of services to children and adolescents in the eight counties covered by the grant. Another collaborative proposal was submitted with Cahaba Mental Health Center to obtain Children's First financing (The Our Kids RFP) to expand intensive home-based services for families in the eight county area (Dallas, Perry, Wilcox, Choctaw, Greene, Hale, Marengo, and Sumter counties). The Substance Abuse Program also received funding for a proposal to expand intensive outpatient substance abuse services to adolescents in three of the counties served by the Board.

A pilot project to address the treatment needs of children committed to the Department of Youth Services (DYS) and returning to the community was in development with the Hale County Juvenile Court (Judge Sonny Ryan). This

project is a collaborative effort between the Board, Hale County Juvenile Court, DYS (Mr. Walter Wood), and the Children's First Foundation (Ms. Kelley Parris-Barnes) to use existing services and programs to address the needs of high-risk children. If successful, this program could be implemented statewide to address aftercare treatment needs of children returning from DYS facilities to the community.

Additional funding was made available through DMH/MR to expand mental illness outpatient services and crisis stabilization services. This funding will allow for the expansion of outpatient services to include an intensive home-based intervention team for mentally ill adults. This team will feature a registered nurse and case manager to intervene with individuals in crisis to provide short -term comprehensive services. Additional crisis stabilization funds will be utilized to support outpatient services and after-hours emergency services to obtain needed hospital beds for short-term treatment. The Board is also working with West Alabama Youth Services (WAYS) to develop a hospital agreement to secure treatment for individuals in detention that may need crisis psychiatric treatment.

As the year drew to a close, the Board was once again saddened by the loss of Ms. Thelma Craig, a long-time Board Member from Choctaw County. Her wisdom, leadership, friendship, guidance, and concern for her fellow citizens will be greatly missed. We will also miss Ms. Caroline Matthews who retired at the end of the year. Ms. Matthews, a Duke University educated mental health professional, was instrumental in the development of WAMHC and its services and was a valued employee/advocate for those suffering from serious emotional illness.

Ms. Kelley Parris –Barnes, Associate Director for Administration left WAMHC accepting the position of Executive Director of the Children's First Foundation, Inc., in Montgomery. Ms. Barnes' duties were split between Ms. Angela Harris, Health and Safety / Risk Management Coordinator and Mr. Derek Osborn, Human Resource Director. Other organizational changes during the year included Ms. Joyce Weiss, Associate Director for Outpatient Services assuming the duties and responsibilities as Clinical Director of Board programs.

The **FY 2002-2003** year proved to be the most financially challenging since The Great Depression for the state of Alabama. The legislature depleted the reserve trust funds held by the state and the fiscal crisis produced a need for tax reform in order to maintain services at status quo. The state deficit is hovering around 600 million dollars and community mental health is facing an 18.8% reduction in funding for the upcoming fiscal year. A referendum is scheduled for September 9, to determine the future of many of our programs and services across the state. West Alabama Mental Health begins the annual planning process for the

upcoming fiscal year in July and ending the first of September. This is when the Performance Improvement Committee determines our progress towards Strategic Planning Goals and our outcomes on Performance Improvement. This year we formulated a Budget Reduction Plan in anticipation of the failure of Amendment #1 and the impact it will have on our organization.

Commissioner Sawyer submitted a plan to Governor Riley for consolidation and closure of seven state facilities for the mentally ill and mentally retarded. This plan, if implemented, will move more consumers into the community allowing them to live in a less restrictive setting. In spite of the looming financial crisis WAMHC and other community mental health agencies are attempting to increase community placement opportunities and supports for those individuals being release from state facilities.

An Intensive In-Home team was put into place to provide more intensive services to Adult consumers of MI services who are considered to be high-risk and recently discharged from the hospital and otherwise identified as crisis-stabilized. This team is located at Glynhaven Apartments and is on call 24/7.

The much desired ARCH (Alabama Rural Communities of Hope) grant proposal was not funded in 2002. Children's First Foundation and the Department of Mental Health and Mental Retardation provided funding for new positions and a new program to be added to the WAMHC Child and Adolescent Program. Two In-Home Intervention Teams were added to provide intensive, home-based treatment for a period of 12-16 weeks with the child and family receiving services. Two Intensive In-Home Case Managers and a Parent Coordinator will join the team. The goal of the Parent Coordinator is to inform and support the efforts of parents having severely emotionally disturbed children to keep those children in the community with appropriate supports in place. West Alabama remains behind in the provision of psychiatric and psychological services to children; reapplication of the ARCH grant will be submitted in October of 2003 in hopes of placing the necessary professional and paraprofessional services to children and families in place.

A Juvenile Court Liaison position was also added and funded with Children's First Tobacco Settlement money. This position networks directly with Juvenile Judges, Juvenile Probation Officers, and mental health staff to assist with referrals developed to divert DMH/MR and DYS commitments.

Emergency Services which provides the necessary 24/7 response to crisis was redesigned to allow for a mandatory emergency response team manned by a bachelor and master's level staff member and are rotated on a weekly basis to respond by phone or face to face for consumers in crisis. This process enhances and helps to ensure the continuity and delivery of crisis services to our

consumers by adding supports for our referral agencies.

Springhill Home provides Specialized Behavioral Group Home services to residential consumers; this is a step down from hospital placement and improves consumer's chances of being successful in the community. Springhill Home is on occasion used to divert state hospitalizations. Occupancy for residential programs has increased 15%-20% within the last six months. Nursing home consumer population has increased by 20%; Foster Home billing is up by 25% due to an influx of new consumers.

For consumers of mental retardation services this has been an exciting year with several new community opportunities emerging. These opportunities resulted in community training sites being established allowing consumers the opportunity to improve activities of daily living by performing tasks in a real setting. (Present)

- Holiday Inn Express
- Food World
- Fairhaven Baptist Church
- The Animal Shelter
- Robertson Banking Company
- Walmart

Community placements where consumers work and are compensated for providing their services consist of: (Present)

- Kentucky Fried Chicken
- St. Leo's Catholic Church
- Newell Paper Company
- McDonalds
- Sonic
- Mobile Crew Assignments
- Walmart

A long-term goal of Kelley Barnes and Patricia Moore was to establish a greenhouse for the consumers to work and learn job readiness and basic living skills. A greenhouse was constructed and donated by Mr. Jim Bird, a long time supporter of West Alabama Mental Health and Marengo Activity Center in particular. Plants are currently growing in the greenhouse and there will be a grand opening and dedication ceremony in the fall. The greenhouse has been aptly named "The Bird House" and will sell plants on a retail basis to the general public. WAMHC over the next two years will develop an atmosphere for consumers to work, learn, socialize and enjoy the growth and development of a business that will supply the City of Demopolis with seasonal bedding plants.

Choctaw Activity Center adopted a volunteer program this year. Consumers volunteer at Willow Trace Nursing Home under Nell Gardner. Consumers assist in activities such as dominoes, cards and helping to move residents to the eating areas by pushing wheelchairs.

Long time Director; Tommy Wright accepted the position of Executive Director with Montgomery Mental Health Authority. Montgomery is home for Tommy and his wife; they left in April to assume new roles in their old community.

Kelley Parris-Barnes returned as Executive Director for West Alabama Mental Health Center, Demopolis being her home. Kelley is the first female Executive Director of West Alabama Mental Health Center and the first to hail from Demopolis. Patricia Moore became Assistant Director when the Board approved the new organizational structure of the center in May 2003.

The Board of West Alabama Mental Health Center also experienced some changes over the last year, the Hale County Commission added Ms. Rita Harless and Mr. Charles Hall to the Board. Mary Louise Rosenbush retired from the Board after 23 years of service; she and her husband donated their historic building on Walnut Street to the City of Demopolis. The Marengo County Commission chose Father Bryan Hatchett to replace Mrs. Rosenbush. Ms. Mandy Ennis, daughter-in-law of our late Board Member Ms. Jeanne Ennis took her place on the Board. Mr. Nat Winn was named to the Board by the Greene County Commission.

County	Population	% Children	% White	% Black	Income	% Poverty
Choctaw	15,922	21.6%	47%	51.6%	$31,870	24.5%
Greene	9,974	29.2%	11.2%	87.4%	$24,604	34.3%
Hale	17,185	29.6%	31.1%	66.7%	$31,875	26.9%
Marengo	22,539	28.8%	37.2%	60.7%	$35,475	26%
Sumter	14,798	29.1%	15.4%	82.2%	$23,176	38.7%

The Strategic Plan which includes a Performance Improvement component, Health & Safety component and Human Resource component is developed using suggestions from consumers, the consumer quality of life survey, referral source (stakeholder) survey, staff survey along with community partners input. Suggestions are used to revise current service delivery and develop new programs when funding is identified. Data is used to support the need for additional services and to identify areas of weakness in current service delivery.

West Alabama Mental Health Center delivers services to approximately 1,900 consumers each month. Although some programs have been phased out due to

changing needs or funding issues, new and innovative programs have been added to meet the needs of the region. Education is offered through the Prevention Program and monitors of stakeholders are routinely taken. West Alabama Mental Health Center employs 83 (+ or -) full-time employees to meet the needs of a growing population. WAMHC is responsive to the needs of the residents of the M-10 Catchment area; monitors are in place to insure the quantity and quality of services offered. WAMHC is readily available, affordable, and responsive to those in needs. Referral procedures are in place for any specialized needs not covered by WAMHC.

In FY 2003-2004 WAMHC is attempting to reduce the growing waiting list of mentally retarded consumers in need of services. Assistant Director, Patricia Moore has been working with State Representative Bobby Singleton to identify funding and facility space in Hale County to open a new Day Program. This would expand existing MR Day Program services from Marengo and Choctaw Counties to Hale, giving consumers in the M-10 Catchment area greater options for services.

Service delivery to consumers has been revised in 2003-2004 to spread intakes across the board to all Master's level therapist in the agency in an effort to move individuals through the system in a timely manner. This process is being tracked by Access-to-Care and the success will be determined by the increased number of intakes and the reduction of no-shows in the system.

During FY 2003-2005 we will track our referral sources through Access-to-Care. We will look at community agencies and organizations that are noticeably absent as referral sources or are limited in their referrals. The school system has been identified as being one of the most obvious institutions with a low referral rate. Once the agencies / organizations / institutions have been identified we will begin to educate them about SMI, SED disorders and introduce them to our services.

Kelley Parris-Barnes wrote a grant in collaboration with the local hospital, Marengo County DHR, and Marengo County Public Health to hire a part-time employee to cover Marengo County assisting individuals in making application for compassionate needs medication programs. This individual did not join the organization until January of 2004 and served 115 individuals in this capacity in the first month of the calendar year. WAMH would like to expand the program in an effort to meet both the mental health needs as well as the primary care needs of our consumers.

The looming issue facing all state and state related agencies at this point is the September 9, tax referendum. We will certainly have an exciting year ahead of us as WAMH plays a crucial role in the delivery of services to the citizens of west

Alabama.

The 2005 -2006 fiscal year brought positive change to WAMH. The fiscal year began the provision of services to evacuees of Hurricane Katrina. Several of the staff members donated time and energy to assist those displaced individuals in shelter and emergency housing. Harrison Black, long time therapist at WAMH, came back to join the "Project Recovery" team to work with those displaced due to the natural disaster. Supervisor's luncheons were held six of the twelve months to discuss programmatic issues as well as guide the leadership in the direction of building a strong workforce through recruitment, orientation, training, evaluation, discipline, and retention.

The waiting list for mental retardation services is supposed to be reduced by 29 individuals in our Catchment area in the 2006-07 fiscal year.

WAMH has known for many years overcrowding is a problem in several offices but the Administrative offices in particular. Expansion of the W. H. Billy Smith Building is growing more unlikely by the day due the unwillingness of the City of Demopolis to agree to an extended lease of the building. WAMH Board has agreed to purchase a building located on Hwy. 80 East to house the Rehabilitation Day Program and several offices. Moving this program off the Administrative Campus will insure uninterrupted service delivery in the future.

In the upcoming fiscal year WAMH is planning on expanding the retirement program to include an agency match for all employees.

WAMH has once again partnered with the William A. Ryan Detention Program to provide therapeutic counseling services to adolescent females in a structured environment as a component of the program.

The Executive Director wrote a grant to the Alabama Department of Transportation to provide our residential programs with two (15) passenger vans. WAMH will open Bell Grayson Manor a (14) single apartment complex in Demopolis in October. Vans will be necessary to transport individuals in the group home, supportive apartments, and now Bell Grayson, our independent living apartments. WAMH is currently running two (10) passenger vans; a 1988 Chevrolet with over 200Kmiles and a 1991 Ford with over 200K miles. Replacement transportation is over due.

WAMH once again made application for a Delta Rural Grant. The purpose of the grant is to continue the program in Marengo County that assists individuals in making application for compassionate needs medication, free or at a reduced cost from pharmaceutical companies. This program, operating with WAMH as the lead agency, has enjoyed much success over the last three years; assisting

258 individuals in successfully securing medication in the 2005 - 2006 fiscal year.

A proposed merger between Indian Rivers Mental Health (Bibb, Pickens, Tuscaloosa), and Mobile Mental Health Authority (Mobile, Baldwin), has the mental health community at odds. A number of community mental health Boards, including West Alabama, have expressed their disagreement with the merger option.

There has been much speculation as to how it would affect the smaller agencies as well as West Alabama Mental Health being the land mass separating the two larger organizations.

In concert with the merger controversy, the Department of Mental Health and Mental Retardation has sponsored and developed state wide regional planning committees. I am in hopes that agencies give this process a chance, bringing private and public enterprise together with stakeholders, local and state government, and consumers creates a unique opportunity to solve some key problems while expanding the scope of service delivery. I sincerely hope that in 2006-2007 we do not see mega - mergers thwarting the valiant efforts of a Commissioner to develop informal partnerships to solve regional problems.

Ms. Carrie Johnson and Ms. Emma Ford joined the Board as appointees from Choctaw County. Hale County Board member Rita Harless resigned citing a conflict of interest.

2006-2007

This has been a development year for WAMH, Mr. Max Joiner was appointed to the Board by the Marengo County Commission and toured the Catchment area visiting facilities and meeting consumers. Bell Grayson Apartments were completed and remain full. The ALDOT van was delivered in May and consumers are enjoying the air conditioned transportation. The Delta Rural Grant was once again funded and expanded to include Marengo, Greene, and Hale counties.

In an effort to alleviate the pressures of not having a full time M.D., Kelley Barnes assembled a group of interested professionals to brain storm the impact of rural v. urban parity in access to health care and look at options for closing the gap. The group consisted of individuals from the Department of Mental Health, Department of Public Health, Medicaid, Legislators, M.D.'s from the University of Alabama College of Community Health and Rural Health, University of South Alabama and Directors of rural Community Mental Health Organizations. The resulting partnerships were rewarding; Molly Brooms and Susan Chambers from the Department of Mental Health presented a proposed Bristol-Myers Squibb opportunity that was embraced by all. The project award was announced

December 5, in Montgomery with representatives from BMS and Governor Bob Riley in attendance. The project includes the 12 Black Belt counties designated by the Governor and begins with Hale, Wilcox and Lowndes Counties in phase one. The goal of the project is to expand behavioral health care capacity in the Black Belt; Blend Behavioral and Primary health care; create sustainable programs; decrease the stigma of mental illness. WAMH has purchased a van, received funding for two Psychiatric Fellowships and has forged a relationship with U of A school of Rural Medicine and Social Work as well as Auburn University's Rural Studio. The Rural Studio concentrates on re-modeling homes for individuals living below the poverty level to enhance their quality of life. WAMHC will partner with the Rural Studio to identify consumers of mental health services who are in need of adequate and/or affordable housing. Improved Quality of Life indicators will be evaluated as a result of the partnership related to these identified consumers. The BMS grant will fund approximately 1.2 million dollars in expansion for three to five years.

WAMH applied for an FCC Grant with community mental health partners from South Central Mental Health, South West Mental Health and East Central Mental Health. The Grant was awarded and will cover installation of fiber optic wire to all offices. This is a 2.5 million dollar grant and RFP will open for bid in the near future.

The Assistant Director developed the Milestone Project with the Department of Rehabilitation and consumers in the Day Programs; both MR and MI. The project currently has 12 individuals working in the community and has been awarded recognition statewide for the Wal-Mart Demopolis store for the partnership. The Demopolis store will now compete on a national level for recognition for the development and implementation for creating job opportunities for individuals with a developmental or mental illness diagnosis.

WAMH is fully staffed at this time and Human Resources has worked hard to implement a retirement program and expand employee benefits. The result of this expansion is a 50% reduction in turn-over. For the fiscal year 06-07 the turn over rate was 14%. The position of Probate Court Liaison was created to insure consistency in evaluation across the five county area, and Phil Plotkin rejoined the staff to fill the need.

WAMH was notified one day prior to contracts being released from the Administrative Office of Courts that Hale County has been removed from our service area for Court Referral. We protested the move to Chief Justice Sue Bell Cobb, resulting in no action. We predict the Domestic Violence Education Program will be decimated by the move noting that 76% of the referrals are generated from Hale County and we will track the effects on the DUI educational and referral programs in the upcoming year to determine if we will continue to

contract with AOC in the future.

WAMH continues to have issues with the City of Demopolis concerning the limited number of years remaining on the lease of the administrative office building. WAMH purchased a building on highway 80 to re-locate the RDP Day Program with the intention of expanding the capacity as well as securing a location for some 44 individuals served daily in the event the lease options are not negotiated in an acceptable manner. The Board voted to name the building after long time supporters of mental health services; Hugh A. Lloyd, Board Attorney; Caroline Matthews, a founding member of the agency; Mr. Nathan Watkins, retired District Attorney; an original Board Member. The Lloyd, Matthews, Watkins, Life Skills Center should open in the winter of 2007.

Senator Larry Dixon submitted a request from WAMH to the Board of Medical Examiners requesting a revision of the medical licensure law allowing for limited licensure of M.D.'s to work in 310 agencies. This request was approved by the Alabama Board of Medical Examiners and now in the Alabama Administrative Code.

The Department of Mental Health funded a local needs assessment that should be tied to funding options through the regional planning process. WAMH was pleased to be able to offer stakeholders of mental health services in the five county area a voice in the planning process. Results are attached, and please note the issues identified as problem areas were previously recognized from survey data. The Child and Adolescent In-Home team was alleviated due to under utilization 72% and stakeholder survey feedback. The majority of concern during the needs assessment meeting was directly tied to Child and Adolescent services.

Renovation will begin December 14, on the Lloyd, Matthews, Watkins Life Skill Center on Highway 80 that will house the Rehabilitation Day Program upon completion. This acquisition will be the most recent in WAMH expansion across the five county area.

2007-2008

WAMHC had the opportunity to strengthen partnerships by participating in several grant/contract proposals.

Years of diligent work to develop partnerships to support quality services to our consumers have paid with the award of the Bristol Myers Squibb/Alabama Coalition for a Healthier Blackbelt (ACHBB) Grant. The goal of the project is to build capacity within the behavioral healthcare delivery system; merge behavioral

and primary healthcare needs; reduce stigma; and continue to expand and develop partnerships. The mobile unit continues to serve four sites in Hale County.

Bell Grayson Apartments remain full. Residential and day program consumers enjoy the use of the ALDOT van and consumers are enjoying the air conditioned transportation. The Delta Rural Grant was once again funded and includes services to residents in Marengo, Greene, and Hale counties.

Dedication of Lloyd, Matthews, Watkins Life Skills Center September 2008.

FY 08-09

Kelley Parris Barnes resigned as Executive Director effective November 2008. She accepted the position of Director Child Abuse and Neglect Prevention for the state of Alabama. Patricia Perry Moore, Assistant Director and 24 year employee at WAMHC was appointed Executive Director by the Board.

Oct 08 Illness, Management Recovery (IMR) implementation

Successful submission of proposal to Alabama Board of Pardons and Parole to provide intensive outpatient substance abuse and re-entry services for probationers and parolees at the LIFE Tech Transition Center, Thomasville.

Full time psychiatrist hired December 2008.

BMS Project: At the invitation of Patricia Doykos, CEO-BMS Foundation, Executive Director presented the accomplishments of WAMHC BMS Project at the Global Health Council Conference, Washington, D.C. in May/2009. WAMHC selected as a recipient for the BMS Employee Giving Campaign 2009.

Continued implementation of the FCC Grant WAMH applied for with community mental health partners from South Central Mental Health, South West Mental Health and East Central Mental Health. Tandberg teleconferencing units were installed at Smith Building, Life Skills Center, Hale County, Marengo Activity Center, and Choctaw Activity Center. The Grant was will cover installation of fiber optic wire to all offices. This is a 2.5 million dollar grant and RFP will open for bid in fall 2009. This installation results in all WAMHC sites having teleconferencing equipment available for use.

Mission, Vision, and Guiding Principles of the Organization

West Alabama Mental Health's Mission Statement (Serving Choctaw, Greene, Hale, Marengo, and Sumter Counties with approximately 1,900 consumers monthly for mental health services)

It is the mission of the West Alabama Mental Health to provide effective and efficient mental health services to individuals meeting eligibility requirements regardless of ability to pay. The organization is committed to continually improve the quality of care and services provided to consumers. West Alabama Mental Health will collaborate with stakeholders to ensure mutual accountability for resource stewardship and system effectiveness. The organization will operate locally responsive programs to meet the needs of the community and promote the development of innovative programs in traditional and non-traditional settings when resources are available.

Vision Statement

West Alabama Mental Health's vision is to provide responsive and accessible services in Choctaw, Greene, Hale, Marengo, and Sumter Counties. Vital to our vision is a commitment to recovery-oriented, consumer-centered care. To ensure this vision of care, WAMH will find ways to flex services and utilize community resources to promote consumer access to necessary and beneficial services. The development of services will emphasize community-based settings to support care within the community and decrease the necessity for institutional care. Care of consumers will be provided in the most cost-effective and efficient manner possible emphasizing a seamless system of care for the consumer. To ensure that consumers in need secure appropriate services, WAMHC will operate efficiently, using the creativity of staff, to retain and reinvest revenue to support organization and system improvement.

Guiding Principles/Values

- Services will be provided in an ethical and responsible manner with a focus on the dignity and rights of the individual.
- Ensure a continuum of basis programs and services.
- Expand programs and services when the resources and need have been identified.
- Use resources efficiently and effectively in providing services.
- Provide services to individuals who are eligible for needed services.
- Serve as an advocate for the rights of those individuals served.

- Provide needed services to individuals in the least restrictive environment.
- Provide needed services at an affordable rate and regardless of ability to pay.
- Work, cooperate, and plan with other community agencies and providers.
- Promote and utilize input from stakeholders.

WAMH is a comprehensive community mental health center providing services to the citizens of Alabama and specifically the citizens of the M-10 Catchment area. These services must be provided in an ethical and responsible manner protecting the dignity and rights of each individual. All staff should focus on this principle in the delivery of all services. WAMH is dedicated to providing a basic continuum of services based upon the needs of the programs as specified by that programs Service Description Manual. It is recognized that services and programs will be developed and expanded when the need for that service has been identified and/or resources are available to support the service or program. To continue the operation of basic programs and services and to ensure that programs can be expanded, WAMH must operate in an efficient manner allowing for the effective use of resources to provide programs for those in need. However, with limited resources and requirements form external resources, programs and services can only be provided to those individuals that meet the specific eligibility requirements of a program or service. Eligibility requirements will be specified not only in provider contracts as part of the Service Description Manuals of WAMH. In providing services to those eligible individuals, it is the responsibility of each staff member to act as an advocate for that individual's moral, ethical, and social rights. In this regard WAMH will endeavor to treat eligible individuals in the least restrictive environment possible. WAMH always keeps in mind that it is our responsibility to promote that individual's ability to succeed and integrate into the community. It is WAMH's mandate and responsibility to provide services at an affordable rate and in many cases to provide services regardless of ability to pay. To accomplish these principles it is imperative that WAMHC cooperate, consult, and plan with other agencies and providers in the community obtaining input from our internal and external stakeholders on a regular basis.

West Alabama Mental Health Board, Inc.
Performance Improvement Plan 2008-2011

Introduction

The West Alabama Mental Health Board, Inc. (WAMH) recognizes and endorses the concept of continuous quality improvement (CQI) or performance improvement (PI) as a key management process. Performance Improvement is a systematic and systemic approach to plan, sequence and implement improvement efforts using information obtained from system wide monitoring efforts. The PI process enables the leadership of the mental health center to collect data (information), analyze the data, and use that data to make informed management decisions to improve the performance of the organization.

The PI process does not replace the normal administrative lines of control, which are displayed in Administrative Lines of Authority flow chart in (**Appendix A)** of WAMH Strategic Plan. The administrative lines of authority are useful in the supervisory process and are often used in the day-to-day operation of WAMHC programs. The PI process enables the administration and leadership of WAMH to use continuous improvement principles to create a systematic approach to management and decision-making. To implement the PI process, WAMHC has approved a management committee structure, which is graphically displayed in (**Appendix A)** of the WAMHC Strategic Plan. Integration of the traditional administrative structure to a data driven management system is one of the ultimate goals of this process.

The leadership, or management committee will be known as the Performance Improvement Committee (PIC), and is chaired by the Executive Director. This committee will provide an overall management assessment of the mental health center and shall make ***recommendations*** directly to the Board of Directors through the Executive Director. The committee structure outlined in the flow chart will provide data, make recommendations and suggestions, and support the PIC in the management process. These committees are:

(1) Management of Information Committee (MIC);
(2) Health and Safety Committee (H&S);
(3) Staff Development and Human Resources Committee (HR);
(4) Behavior Plan Review Committee (BPRC);
(5) Human Rights Committee (HRC).

The management committee structure and process is comprehensive and encompasses the monitoring, evaluation and continuous improvement of the clinical and non-clinical services of WAMHC. The committee structure communicates recommendations, findings, decisions, etc., through the system of administrative supervision.

Philosophy

The approved committee structure will incorporate continuous performance improvement concepts in the management of the organization. Essential to these efforts is the inclusion of input from consumers, family, stakeholders, and staff in the performance improvement process. The PIC will assure that information from consumers, family, stakeholders, and staff is obtained through surveys, meetings, suggestion boxes, and any grievance reports. WAMHC will utilize current Quality Assurance efforts, and Quality Improvement methods to develop a systematic approach to performance improvement. The Board feels that continuous performance improvement should focus on the process not the product and is best represented by the Shewhart cycle, or Ishikawa circle, of Plan --- Do --- Study --- Act.

Committee Structure and Authority

Board of Directors:

- Has overall responsibility to oversee and govern the Center;
- Delegates authority and responsibility for the management of the Performance Improvement process to the Executive Director.

Executive Director:

- Shall be the chair of the leadership management committee (PIC), and serve as a standing member of all other committees;
- Will develop plans and implement procedures to assess and improve the quality of the organization's governance, management, clinical, and non-clinical support processes through the PIC and committee structure;
- Will have individual responsibility for the day-to-day operation of the performance improvement process.

Performance Improvement Committee (PIC):

- Will serve as the leadership or management committee of the mental health center;
- Will be responsible for formulating **recommendations** to improve the overall organizational performance;
- Will develop and review the mission, vision, and value statements of the organization;
- Will use information obtained form these efforts to develop the Organizational Strategic Plan with goals, objectives, monitors, and indicators for the agency;
- Receives and processes recommendations from the Staff. Has management and oversight of issues related to **Rights, Responsibilities, and Ethics;**
- Will develop and recommend policies and procedures concerning consumer rights, organizational code of ethics and shall ensure that consumer and family feedback is reviewed and integrated in the decision making process of the organization;
- Will receive information and recommendations from the committee structure of the agency both standing and ad hoc.

Management of Information Committee:

- Is responsible for the oversight of clinical records, utilization review and coordination/evaluation of business and billing efforts of the mental health center;
- Shall develop and submit to the PIC an annual Management of Information Plan that will discuss the design and implementation of quality indicators to measure compliance with WAMHC clinical procedures, and Alabama Department of Mental Health (DMH) clinical standards or any other credentialing agency;
- Is responsible for formulating Corrective Action Plans for incidents that may occur within the agency related to the management of clinical records, standard business practices, billing efforts or information gathering;
- Will be responsible for the monitoring of issues related to Pharmacy, Therapeutics, and Nutrition along with the Health and Safety Committee.

Health and Safety Committee:

- Will monitor, evaluate, and manage the safety, risk management, and infection control functions of WAMHC;
- Will develop an annual Health and Safety Plan, which will serve as the manual and protocol for health and safety issues;
- Will develop and recommend policies and procedures for health and safety issues;
- Will be responsible for the monitoring of issues related to Pharmacy, therapeutics, nutrition and transportation, along with the Management of Information Committee.

Staff Development and Human Resources Committee:

- Will develop and annual Staff Development Plan and will monitor and evaluate staff needs, staff development and education, and the credentialing/privileging process of the mental health center;
- Will oversee the WAMHC hiring process; establish standards for staff qualifications and supervision, ensure staff competence, and monitor activities for staff orientation, training, and other educational activities;
- Review and revise employee handbook and WAMHC Board policies and procedures annually.

Behavior Plan Review Committee:

- Oversee the development and implementation of Behavior Support Plans;
- Approve, monitor and review Behavior Support Plans.

Human Rights Committee:

- Review any restriction or violation of a consumer's rights;
- Review and/or investigate any imposed restriction of a consumer's right and review documentation to guarantee due process.

Performance Improvement and Quality Assurance Activities:

Performance Improvement and Quality Assurance activities will include the review and adoption of new forms, chart review / audits, internal compliance activities, and correction / follow – up of chart audit findings. WAMH will seek certification from DMH for the administrative structure and activities as well as service programs. WAMH recognizes DMH will conduct periodic certification site reviews of programs for the purpose of evaluating compliance with the minimum standards established by DMH. Deficiencies, requirements, findings, suggestions, or other reports developed by DMH personnel as the result of a certification site visit will be reviewed by the Performance Improvement Committee and an action plan will be developed by the Executive Director and Program personnel as needed.

Consumer advocates employed by DMH and the advocates of ADAP, will be provided full and immediate access to WAMH programs, personnel, consumers, and facilities. Advocates provide WAMH with monitoring reports as necessary to bring consumer care issues to the attention of the organization for review and remediation if needed. Monitoring reports are typically program or facility specific and concentrate on areas of concern that require immediate attention. Monitoring reports will be maintained by the Administrative Assistant in a confidential manner and reviewed by PIC or the Health and Safety Committee if problems are indicated. If problems are indicated they will be addressed through the performance improvement process and a corrective action plan developed. Advocacy reports will be reviewed for any negative trends in program quality on an annual basis.

WAMH is subject to periodic regulatory inspections or certifications as required by DMH, local ordinances or local codes. When such visits result in the identification of an immediate need for corrective action, the report will be addressed immediately through the appropriate quality improvement processes. Any issue determined to indicate a negative trend for the organization will be addressed immediately.

Identification and Reporting of Special Incidents:

WAMH Performance Improvement process insures for the review, investigation, and correction of incident / accident reports. A component of that process includes full cooperation with the staff and requirements of DMH regarding reporting of special incidents.

WAMH formally adopts DMH's definition of situations or occurrences described as "special incidents" as published in the current edition of DMH's *Certified Community Programs Special Incident Reporting Procedures.*

The reporting of special incidents is detailed in the DMH Community Program Standards Manual. These standards contain definitions of abuse / neglect, protection of mental health consumers from harm, and reporting of certain special incidents to DMH. Events designated as "serious special incidents" must be reported to DMH within 24 hours of the

event. Other serious incidents will be reported to DMH on a monthly basis with follow-up reports filed as needed or requested.

Serious incidents and serious special incidents are those events as defined by DMH standards and that occur in a community residential program operated by WAMH or in a community residential program operated through a contractual agreement; any program certified by DMH; any program operating on the premises of a facility that houses a program operated by WAMH; or a special incident that occurs during the delivery of a program or an event sponsored by WAMH.

Special Incidents:

- Death – any death of a service consumer from known or unknown causes;
- Major Personal Injury – any injury sustained by a service consumer that is rated at a level of 4 or greater on the DMH Severity of Injury Scale;
- Suicide Attempt – any attempted suicide by a service consumer regardless of the resulting injury;
- Suspected Sexual Assault – (alleged perpetrator is a service consumer and reported victim is a service consumer): any sexual contact this is non-consensual, that involves at least one party who is unable to offer consent, or when either party is under 16 years of age;
- Allegations of abuse / neglect as defined by the following statements:

  Physical Abuse – Any intentional assault by WAMH staff upon a service consumer that includes but is not limited to hitting, kicking, pinching, slapping, or striking any consumer in any manner, or otherwise applying physical force with intent to harm regardless if an injury results from the action;

  Sexual Abuse – any sexual contact between a WAMH staff member and a service consumer that occurs when an employee is on or off duty. Sexual contact includes but is not limited to any form of sexual intercourse and any and all forms of sexual contact;

  Neglect – Any action of a WAMH staff member, through reckless conduct, carelessness, or inattention to duty, that exposes a service consumer or a group of consumers to harm or the threat of harm.

  Types of Neglect include but are not limited to the following:
  - Leaving a consumer program area unattended when consumer are present, (except in emergency situations that call for staff assistance);
  - Failing to appropriately supervise consumers when such supervision is required by the staff members job description;
  - Failing to meet the consumers needs for safety, nutrition, medical attention, or personal attention (personal attention if called for in the consumer's Plan of Care);
  - Failing to provide treatment as called for in a consumer's established Plan of Care;
  - Utilizing treatment techniques, such as restraint / seclusion;

- Any action that violates DMH standards regardless of a sustained injury.

Exploitation – any action taken by a WAMH employee that results in the personal gain for a staff member and that includes but is not limited to the borrowing of funds or personal possessions from a consumer, using consumers to perform tasks assigned to the employee, using consumers for personal gain off the grounds of a facility owned or operated by WAMH, or using a consumer to engage with other consumer's otherwise un-accessible to the staff member.

Mistreatment – any action, verbal or non – verbal, made by a WAMH staff member that implies or suggests intimidation or aggression, including but not limited to withholding of necessities, withdrawal of a consumer's personal possessions as a means of control, any false statements made by a WAMH staff member that demeans a consumer or may reasonably be expected to cause a consumer to experience shame, that humiliates a consumer, that threatens a consumer, that are derogatory to a consumer, that are obscene, or that tease or taunt a consumer.

Verbal Abuse – any verbal statement made by a WAMH staff member that demean or cause a consumer to experience shame, humiliation, threats, statements that are considered derogatory, obscene, tease or taunt a consumer.

Serious Special Incidents:

- Self – inflicted injury that requires hospitalization;
- A consumer injury that results from an assault from any other person and requires hospitalization;
- Suspected rape or suspected sexual assault of a service consumer;
- Any death of a service consumer that results from a self-inflicted injury or assault from another person; or from any form of an accident;
- Any death of a service consumer that is suspicious in nature;
- Substantiated cases of abuse and / or neglect;
- Any incident that requires that law enforcement officers be called to a WAMH location;
- Any incident that involves unplanned media exposure;
- Any incident that involves major damage to a building or that otherwise calls for the evacuation of consumers from a building, the relocation of consumers, or the hospitalization of a consumer as a result of damage to a building.

The Board of West Alabama Mental Health expressly authorizes the Executive Director to report incidents to DMH that are severe in nature but are not outlined in the definition of special incidents or serious special incidents. The Executive Director is permitted to make incident reports to DMH at his / her discretion when deemed necessary.

Serious Incidents as outlined in the DMH standards will be reported in the manner consistent with reporting requirements:

Intellectual Disabilities IPMS timeframe – (verbally 24 hours) - 72 hours written report, RCS II; Mental Illness – 24 hours

Investigation of Special Incidents:

WAMH employees responsible for investigating special incidents will complete any educational or training program(s) required by DMH. Investigation findings will lead to follow-up corrective action in an effort to prevent future incidents or the expanded involvement of DHM or other agencies which may have authority over the incident.

- Investigations on Special Incidents will begin immediately;
- WAMH will complete the investigation within (15) days of the initiation date. In cases where other agencies may be involved and reports are not available within the established time frame, the absence of their report will not delay the investigative efforts of WAMH;
- Special Incident investigations will follow any established DMH guidelines when applicable;
- WAMH staff appointed to investigate special incidents may request technical assistance from DMH personnel if it may result in a more comprehensive investigation or when the incident involves a death or sexual assault (consumer on consumer or staff on consumer).

Consumer and Family Member Satisfaction:

WAMH will cooperate with and participate in the assessment of consumer service satisfaction, family member service satisfaction, and consumer quality of life satisfaction surveys as provided by, or arranged by DMH, in addition to any surveys or assessments conducted by WAMH. WAMH will also develop and use survey instruments to assess the perception of service to consumers and his / her family members regarding the quality if services he / she receives from WAMH in the areas of prevention and substance abuse. The confidentiality specific of service data collected from consumers and family members will at all times remain confidential.

As a general rule any survey conducted that receives below a 75% satisfaction rating, the issues noted will be addressed through the corrective action process and monitored more closely for further analysis and possible investigation.

Program Utilization:

WAMH will monitor the utilization of all programs to assure clinical resources, beds, staff, and services, are being used in the most efficient manner possible. Each residential program operated by WAMH will establish expected length of stays (LOS) for that particular program; this will be included in the program description. The analysis of actual LOS against program LOS may reveal program inefficiencies or other issues such as such as cultural shifts in the program emphasis. Admission criteria established in clinical program

descriptions should be analyzed by conducting periodic record audits which reviews the admission information and appropriateness of service, for a randomly selected sample of program records during quality assurance reviews.

Review of Treatment Plans:

Compliance with DMH Standards for treatment plans and treatment plan reviews has been identified as a critical item for performance improvement activities. Treatment plan compliance is monitored regularly as part of the WAMH quality assurance record audit process. Critical items for record reviews selected for the treatment planning process should include an assessment of the following:

- The timely development of each reviewed intervention plan;
- An assessment of the appropriateness of the planned intervention related to the problems presented by the consumer that call for intervention;
- A review of service documentation to compare the content of the service notes with the planned interventions;
- A review of referrals to other services if such referrals were called for in the service plan;
- A review of modifications that may have been made to a service plan to adapt the plan to the changing needs of the consumer.

Treatment plan reviews will be incorporated into the regular quality assurance reports of the Management of Information Committee and submitted to the Performance Improvement Committee for review.

Performance Improvement Process Overview:

The Strategic Plan and Performance Improvement Plan covers the review of each committee including:

- The purpose of each committee;
- The membership of each committee;
- The reporting structure of each committee;
- The committee interface plan.

Individuals involved in the execution of the performance improvement process will complete training offered by DMH regarding performance improvement activities (if applicable).

The performance improvement process will incorporate input from consumers, families, staff, and stakeholders. The PI / QA process will incorporate quality principles in the management of the organization. Data will be collected on clinical, non-clinical, administration, physical plant operations and processes. WAMH will strive to maintain a continuous cycle of information flow. The established committee structure which was approved by the Board of Directors in 1999 was designed to implement the annual Performance Improvement Plan and program.

Development of the Plan:

The PIC reviewed and listed the existing monitoring activities from FY 2007-2008 of the mental health center. These monitoring activities are listed on the Performance Indicator Overview 2006-2007, of the Strategic Plan. The PIC revised the performance improvement indicators in 2007-08 by using the DMH site review results, stakeholder surveys, town hall meeting input and employee surveys. This will enable the committee structure to continue the performance improvement process in a logical structured manner. As the process continues to mature indicators will be revised and the new indicators will reflect a historical timeline of the Performance Improvement process.

Input form stakeholders was obtained through the Consumer and Family Surveys in 2008, Referral Source Surveys, Staff Surveys, Internal Grievance Process, Suggestion Boxes, community group meetings and local Children Policy Councils.

Approval and Update:

The PIP will be reviewed and/or revised annually by the PIC. The Plan will be submitted to the WAMHC Board of Directors at the September meeting. The Plan will begin October 1st of each year and end September 30th of the next year. Indicators shall support the mission, vision, guiding principles, and goals ad objectives of the mental health center. A summary of the previous year's activities shall be included in the Strategic Plan. As a continuous performance improvement process the indicators, performance measures and process for the next year will be established by activities of the previous year. However, some indicators or performance measures may be developed based on DMH requirements, other stakeholders, and national behavioral healthcare organizations. Each July the PIC will request input form each committee for the new/updated PIP. The PIC will review the input from the committees and analyze the current indicators and performance measures. The updated PIP will be finalized at the first meeting of the PIC in September and submitted to the Board in September of each year for review and approval

Scope:

With the approval and implementation of the WAMHC Committee Structure, the Performance Improvement Committee (PIC) has become the management team for the organization and has the responsibility for the implementation and development of the Performance Improvement Plan. The scope of the PIP is comprehensive and will involve the monitoring, evaluation, and continuous improvement of clinical and non-clinical services delivered to consumers of the organization as well as the operational functions of the organization. The PIP will include monitoring and evaluation of representative samples of clinical services, non-clinical aspects of care, and those processes that operationally promote effective and efficient delivery of care and services. The PIP will identify specific indicators to review and will identify the performance measure(s) used to monitor the indicator. The performance evaluation and collection of information will occur in the committees established by the Board and overseen by the PIC.

The WAMHC performance improvement process will address the following functional areas of care and management: Leadership; Improving Organizational Performance; Management of Human Resources; Management of Information; Management of the Environment of Care; Surveillance, Prevention, and Control of Infection; Prevention; Rights, Responsibilities and Ethics; Assessment; Clinical Care; Education; and Continuum of Care areas are monitored and addressed by a committee in the WAMHC committee structure.

Communication of the Plan:

After approval by the Board, a copy of the PIP will be given to each member of the PIC and each Program Director. The Center Director, as Chair of the PIC, will present the PIP to the committee. Committee Chairs will discuss the PIP at each committee meeting and will be responsible for incorporating indicators and performance measures into the specific committee plan. The PIP will be discussed each year with all staff at an annual in-service meeting. This in-service will usually occur in October after the PIP has been approved by the Governing Board. The PIP will also be included in the orientation of all new employees.

Forms:

The PIC has approved several forms for use by all committees. These forms include:

- Agenda form;
- Task Log;
- Corrective Action Plan form
- Incident/Accident Report form and Incident/Accident Report Log;
- Cost Analysis Information form.

Please see **Appendix B** to review the forms.

A. The **Agenda** will include:

(1) Title of the meeting;
(2) Date of the meeting;
(3) Place of the meeting;
(4) Start and end time of the meeting;
(5) Agenda items for the meeting;
(6) Attendance record for the meeting (with titles of those members attending);
(7) Meeting notes which must address each agenda item;
(8) Signature and date for the person recording or preparing the agenda report.

B. **Task Log** will be used by the committees to indicate assignments made by the committee during any given meeting. The task log will be attached to the Agenda for appropriate follow-up.

The **Task Log** will include:

(1) Name of the committee or meeting;
(2) Committee chair;
(3) Date the task log was started/initiated;
(4) Date the task log was completed;

For each Task:

(1) Date the task was assigned;
(2) Topic of the task;
(3) Task or activity assigned;
(4) Person(s) responsible;
(5) Completion date assigned for the task/activity;
(6) Follow-up date to monitor work on the task/activity;
(7) Results of the follow-up;
(8) Comments about the task/activity or process.

C. Corrective Action Plans:

(1) Will be used for a variety of purposes.
(2) Will be used in the corrective action process to:
- Address inappropriate or substandard service provision;
- Address issues when services are not provided;
- Address issues when performance indicators or other quality monitoring activities are not being met.

The Standing Committees along with the PIC are delegated responsibility for making recommendations for corrective action concerning a quality issue and ensuring that the corrective action plan is implemented. The corrective action plan includes two sections:

- Section one completed by the individual identifying the problem;
- Section two is completed by the individual or group delegated to complete the corrective action task.

D. Incident/Accident Reports:

Incident/Accident Reports will be used to document complaints, grievances, accidents, bodily fluid exposure reports, disease/illness reports, or other significant or unusual event involving clients/consumers, visitors, employees, consultants, processes, or contractors.

The Incident/Accident Report will contain:

An initial section completed by the employee that observed the event or was informed about an event. This section notes the name of the person involved in the event, their sex, client number, the location of the event, and the immediate action taken concerning the event.

- The employee and the designated supervisor (if in need of assistance) will fill out the next sections. The employee will complete the checklist on the form for:
- type of consumer or non-client;
- category of event;
- type of occurrence, and type of injury or complication

If the event involves a concern involving medication, a pharmacist or RN must be contacted prior to completing the medication section.

The final section is completed after the event has been reviewed. The Executive Director, Assistant Director or designee completes this section. The report is given an ID number and logged on the Incident/Accident Report Log.

All Incident/Accident Reports and the Corrective Action Plans will be logged on the Incident/Accident Report Log, which will be used to monitor and track all reports. This form will include the date of the event, the identification number of the report, the individual involved in the event, the category of individual(s) involved (client, visitor, employee, etc.), the location of the event, and the category of the event, the action taken, and resolution of the event.

E. Cost Analysis Information Form

The Cost Analysis Information form will be used to evaluate programs and to determine costs and revenues related to each program in the WAMHC planning process annually. The form is basically divided into two broad sections. The first section breaks out the costs associated with a program. This includes costs related to personnel and benefits, operating expense related to a program and expenses related to room and board if applicable. The second section breaks out revenues for a program from fees to third party payments.

F. The PIC will use **Performance Improvement Indicator Form** to document those issues monitored by the committee.

This form will indicate:

(1) Name of the indicator;
(2) Initiation date of the indicator;
(3) Review/revision dates for the indicator;
(4) Purpose of the indicator;
(5) Action steps of the indicator.

Each indicator will have performance measures, which will be utilized to collect information on the identified indicator. The Performance Improvement Indicator form will also document:

- Dimensions of performance;
- Reference;
- Data source/tool;
- Method of data collection;
- Size of sample used;
- Threshold;
- Responsible staff;
- Reviewed by;
- Reported to;
- Frequency or time frame for the report.

Each committee will submit reports on monitoring activities to PIC at least quarterly (Unless otherwise indicated).

These reports will note the committee and will provide a brief report on each assigned indicator or monitoring activity. If the data indicates issues or concerns, committees will develop CAP's to address these concerns or obtain additional data by expanding monitoring activities. A Corrective Action Plan (CAP) is then developed and submitted to PIC for review and approval. When the CAP is approved, MIC will then monitor the effectiveness of the CAP.

Committee chairs will verbally / or in a written report update PIC on monitoring activities on a monthly basis. These reports will be attached to, or noted in, the PIC minutes for that meeting.

Performance Improvement Teams

Performance Improvement Teams (PIT's) are critical to improving performance and reducing or eliminating the causes of quality problems at the mental health center. To be effective these teams must be focused and understand their mission and role. In the WAMHC Committee structure, PIT's operate as ad hoc teams appointed to address specific issues. The PIT may be an ongoing, long term team, point-in-time specific or a short-term

team that is disbanded as soon as their task is accomplished. In most cases, PIT's will be formed as a result of corrective action plans to make improvement recommendations, monitor the effectiveness of the recommended action plan, or identify further opportunities for improvement related to the issue at hand.

The Performance Improvement Committee may appoint PIT's or PIT's may be appointed at any level of the committee structure if approved by the PIC. In other words, any committee may recommend the formation of a PIT as part of the performance improvement process and may implement the PIT on approval by the PIC. The PIT will then report directly to the committee under which it is formed. The committee will then report the recommendations or information collected by the PIT to the PIC.

All PIT's will work to develop an improvement plan for the area they have been assigned; follow continuous performance improvement principles (plan-do-study-analyze); collect data using performance improvement tools; keep accurate documentation using approved forms; consider alternative approaches; and present the results of their efforts to their appointing authority.

Performance Improvement Tools

Performance improvement tools are devices that can be used to help understand performance improvement issues, analyze information, and improve organizational processes. Some of the basic tools used in performance improvement are: flow charts, cause and effect diagrams (fishbone diagrams), pareto charts, scatter diagrams, histograms, run charts, and control charts. These methods have not been traditionally used with staff of the mental health center so in-service trainings on Quality Management are scheduled annually with the leaders of the organization. Maxwell Air Force Base delivered the training this year to Program Directors and supervisors of the organization and is scheduled to deliver another training for mid-level supervisors in early 2006.

Flow charts use a graphic representation of the steps in a process. Flow charts help to understand a process, identify critical stages in a process, locate problem areas, show relationships between steps in a process, and identify those responsible for completing different steps in a process.

Cause and effect diagrams illustrate the relationships between a given outcome and the factors that influence the outcome. The Fishbone Diagram is useful in portraying a complex issue and may help to understand, analyze, and improve the issue or process.

A Pareto chart is a bar chart used to separate the major problems from the many possible problems. This process enables improvement efforts to be more focused; analyze information according to a priority of importance; and determine which problems are most important using information and not perception.

Scatter diagrams reveal possible relationships between two variables. This tool helps to determine possible cause of a problem and identify any relationship between two variables.

A histogram is a bar graph that shows the central tendency and variability of a data set. Histograms can help to understand the variability of a process and determine the underlying distribution of a process.

Run charts are graphs that show the changes in a process measurement over time. Run charts may assist in recognizing abnormal behavior in a process and document that change over time. A control chart in similar to a run chart in that it allows us to see how a process varies over time. however, a control chart includes statistically generated upper and lower control limits.

Corrective Action Plans

An integral part of the continuous performance improvement process is the corrective action plan process. Every PIP must have established procedures for taking appropriate action whenever inappropriate or substandard services are provided; when needed services were not provided; and when performance indicators, audits, focus studies or other quality monitoring activities indicate that performance standards are not being met. Corrective Action Plans will be tracked using the **Corrective Action Plan** form **(Appendix B).** The Corrective Action Plan form will document any issue or problem at the mental health center.

Every effort should be made to resolve performance improvement problems/concerns by delegating authority and responsibility to the lowest level possible. If this cannot be accomplished the problem/concern should be documented on a Corrective Action Plan form and sent immediately to the Executive Director, or designee, for review, categorization, and task assignment. In all instances, the scope of the problem, likely causes, assessment method, and criteria for resolution are to be reviewed and approved by the PIC including assurance of the originator of the report that the problem is resolved. In the instance where the plan of correction may require the authority or approval from sources external to the mental health center, the PIC shall document that such approval was sought, was approved, and if unapproved, shall state the reasons why such action was refused.

The effectiveness of the PIP depends on the ability of the plan to impact the care, service, systems, and processes of the mental health center in a positive and efficacious manner. Establishing standards, monitoring performance and outcomes, identifying problems and opportunities for improvement, and developing and implementing corrective action are a key component. However, corrective action must be effective in improving the quality of care and operations of the mental health center. For the PIP and corrective action process to be effective the continuous performance improvement initiative must ensure that the

results produce desires, appropriate change; that the change, when instituted, is maintained; and the result is in improvement in the quality of care/service to our stakeholders as reflected in our practice patterns and operational functions. In other words, change for the sake of change does not necessarily improve the quality of the organization. The PIP and changes made through the corrective action process should make sense and improve the operations of the organization.

Procedures for Corrective Action

1. Corrective Action Plan reports, may be generated by any staff member or committee member in an effort to identify opportunities to improve consumer care, potential consumer care problems, concerns, and other issues that may include but are not limited to the following:

   - Over-utilization or under-utilization of services
   - Issues concerning rights and confidentiality for consumers
   - Maintenance of consumer records
   - Over-utilization or under-utilization of resources
   - Over-utilization or under-utilization of personnel
   - Plant management and safety
   - Infection Control
   - Absence of, or inconsistent application of policy
   - Billing issues or concerns
   - Service delivery issues or concerns
   - Consumer care issues or concerns
   - Areas that impact on agency image and community relations

2. All Corrective Action Plan reports will be sent to the Executive Director as Chair of the PIC, or the Assistant Director if designated. The Executive Director will review all recommendations for improvement/action to identify opportunities to improve consumer care, potential consumer care problems, concerns, and/or needs. The initial review of the Corrective Action Plan will include the following:
   - Determine if the problem/concern is specified.
   - That the individual/committee identifying the problem/concern is specified.

3. The person/committee responsible for the corrective action will take action based on the identified problem or concern.

4. The written action plan must include (as appropriate):
   - Specific action to be taken and suggested monitors for effectiveness;
   - A specific schedule for implementing the corrective action designates the person(s) responsible for implementing the action(s), and designates the person(s) responsible for follow-up monitoring of action effectiveness;

- The action plan includes the means to modify the action(s) if improvement does not occur within a specified period of time;
- The plan provides for notification of the appropriate persons involved and the requirements of the corrective action. The method, type, style, and schedule for notification is to be included in the plan;
- The action plan includes a reference to the method and time frame for providing feedback about the effectiveness of implemented corrective actions;
- Document all steps in the corrective action process and make sure written plans are included in appropriate committee minutes;
- Make sure corrective action is listed on the appropriate committee Task Log;
- All Corrective Action Plans must be returned to the PIC for review and follow-up.

5. The Committee or person(s) developing the corrective action shall be responsible for monitoring that plan of action until complete. Verification of resolution of the problem/concern may be established in several ways, among them are:
   - Reviewing data collected after the corrective action is instituted to determine replication, significant redirection or elimination;
   - Direct observation of the activity or personnel;
   - Surveying pertinent staff, consumers, or others;
   - Repeating the study with different personnel and using new, revised or identical assessment criteria;
   - In the event that the corrective action plan fails to correct the problem/issue this should be documented and sent to the PIC immediately for review.

Accountability to the Governing Body

The West Alabama Mental Health Board, Inc. has identified the Performance Improvement Committee (PIC) as the entity responsible for oversight, development, implementation and evaluation of the continuous Performance Improvement Program. The PIC will submit quarterly monitoring reports to the WAMHC Board as well as an annual PIP.

Upon approval of the PIP by the Board, the PIC implements the PIP according to protocols established and provides ongoing monitoring for plan compliance, continuity, and effectiveness. During the final quarter of each year the, the Executive Director and PIC begin the process of preparing an annual summary of PIC activities and an evaluation of the effectiveness of the performance improvement process. This summary of the activities and effectiveness of the previous year's performance improvement efforts will be included in the next year's Strategic Plan which will be presented to the Board at the September meeting for review and approval.

Confidentiality

In an effort to protect consumer confidentiality, all copies of minutes, evaluations, monitoring activities, status reports, incident reports, and other performance improvement related data will maintained by the Executive Director or designee. Performance improvement records shall not include names of consumers (WAMHC consumer case numbers should be used when an individual must be identified). Access to confidential performance improvement information is restricted to the following individuals:

- Administration
- Governing Board Members (when necessary)
- PIC members

West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Business/Administration

Initiation Date: October 1, 2007 **Review/Revision Dates:** **September 30, 2009**

Purposes: Monitor the external and internal forces affecting the agency.

Action Steps: **PI # 1**

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Monitor staff productivity	Monthly Productivity Report developed by CMHC/MRSIS/ASAIS	X		100%	70% and above	PIC/Business/ Administration/Board	PIC-Monthly Board-Monthly	PIC - Monthly Quarterly
2. Monitor paperwork of vans from 5309 & 5310 grant.	ALDOT Paperwork & Reporting Process	X	X	As required by ALDOT / WAMH / WAPT	100%	Residential Staff/ H &S Committee Asst. Director	Residential/ Business –Monthly	PIC/H&S/ALDOT Quarterly
3. Reconciliation of clinical schedules with chart documentation	Billing/Chart Spreadsheet and CMHC	X	X	100%	100%	Review Staff/Billing HIM OM	CD/Board/Review staff/Billing Daily, Monthly	PIC /Board Monthly
4. Monitor confidentiality of the information system	CMHC	X		100%	100%	HIM/BM	PIC/Administration/ BOARD Monthly	PIC/Administration /Board Monthly
5. Monitor MCD charts and billing sheets for corporate compliance	Billing Charts	X	X	100%	100%	HIM/CD/BM	Administration/MIC/ PIC/Board Monthly	Administration Monthly PIC Quarterly
6. Develop and monitor the annual budget	Budget	X	X	100%	100%	BM/ED	ED/BOARD Annually	ED/BOARD Annually
7. Monitor MCD and State billing for accuracy	Billing	X	X	100%	100%	BM/Billing	ED/Board Monthly	PIC/MIC /Board Monthly

*Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
8. Monitor Internal Compliance with records and MCD billing	Billing	X	X	100%	100%	BM/CD/HIM	CD/Administration/ Board Monthly	PIC
9. Complete Audits and cost reports as required	CMHC	X	X	100%	100%	BM/PD/ED/BOARD As needed	BM/PD/ED/BOARD As needed	PIC/BOARD As needed
10. Monitor GL Posting of expenses in departments	CMHC	X	X	100%	100%	PD/AP/ED	PD/ED/BOARD Monthly	PD/ED/BOARD Monthly
11. Quarterly Reports: -Grant Balances -Crisis Funding	CMHC	X	X	100%	100%	BM/AP	Administration Quarterly	Administration Quarterly
12. complete and monitor expense and income reports for residential consumers	Bank Statements /Income Reports		X	100%	100%	AP/BM/RSM/RA	BM/RC/ Consumers Monthly	BM/RC/ Consumers Monthly

A = Automated M= Manual

*Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.

West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Clinical QA

Initiation Date: October 1, 2007 **Review/Revision Dates: September 30, 2009**

Purpose: Monitor services in compliance with DMH standards and clinical care guidelines.

Action Steps: PI # 2

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Schedule Monitoring of charts in compliance with DHM and WAMH standards. Administrative, Clinical, Medical	DMH Standards Checklist / WAMH chart review sheets	X	X	TBD by Clinical Director & Health Information Manager	100% Compliance	C D and HIM	Ongoing PIC Monthly Board Quarterly	PIC /MIC - Monthly Board – Quarterly
2. Monitor effectiveness of BSP	BSP Reviews Risk level assessments		X	100%	100%	Behavioral Review Committee(BRC)	PIC Quarterly	PIC Quarterly
3. Clinical follow-up with HR consumers.	Charts High Risk List	X	X	100%	100%	C D P. Plotkins Clinical Staff	Monthly PIC	PIC MIC - Monthly Board Quarterly
4. Ongoing monitoring of consumer caseloads	CMHC / Charts	X	X	100%	100%	CD / HIM	C D / P D /MIC Ongoing	E D and A D Annually/ as needed
5. Monitoring of all consumer lab work and compliance with reviews	Medical Charts Spreadsheets CSR		X	100%	100%	Nursing Staff/ RN Supervisor	RN Supervisor C D Ongoing	PIC Quarterly
6. Survey stakeholders in each program service area annually.	Survey tool to be reviewed by Aug. 30th		X	All determined stakeholders	100%	Executive Staff	Executive Staff Annually	PIC/Board Annually
7. Monitor NDP Compliance	Incident/Accident forms. NDP reporting forms		X	All errors	100%	RN Supervisor	Ongoing	PIC

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West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Residential Services

Initiation Date: October 1, 2008 **Review/Revision Dates: September 30, 2009**

Purposes: Empower consumers to continue to meet goals concerning residing in the least restrictive setting.

Action Steps: PI # 3

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Monitor contact with families of residential consumers	Visitor list and requests; weekend and holiday leave forms		X	100%	100%	Residential Coor. / Assigned staff	Quarterly C. D.	Quarterly PIC
2.Monitor progress of IMR with consumers	Tools indicated by IMR trainer(s).		X	100% of residential consumers	100%	IMR Practitioners	IMR Practitioners As completed	PIC/IMR Staff/Consumers /DMH
3. Monitor progress toward BLS goals 90 days for revision or D/C	BLS Goals		X	100% of Residential	100%	As assigned by C.D.	Monthly	Clinical Director Monthly / MIC
4. Nursing Homes monthly	Monitoring Sheets		X	100%	100%	Residential Coordinator	RC/CD Monthly	PIC Quarterly
5. Monitor LOS for residential services	Monitoring Reports		X	100%	100%	Residential Coordinator	Quarterly	PIC/BOARD Quarterly

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*Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.

West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Human Resource Management

Initiation Date: October 1, 2008 **Review/Revision Dates:** **September 30, 2009**

Purposes: Monitor facilities and staff to insure compliance with policy, standards, and governing regulations.

Action Steps: PI # 4

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Monitor emergency drills monthly	E – drill form		X	100%	100%	Safety Officer HR Coordinator	Monthly HR Coordinator	PIC Quarterly
2. Monitor facility checklist monthly	Facility checklist forms and DMH / MR checklists		X	100%	100%	Safety Officer Maintenance Sup. HR Coordinator	Monthly HR Coordinator	PIC Quarterly
3. Monitor Training Plan Compliance	Organizational Training Plan	X	X	100%	100%	Supervisors / Staff HR Coordinator	Ongoing HR Coordinator	PIC Quarterly
4. Monitor 90-day orientation compliance	90 – day form		X	100%	100%	HR Coordinator	Ongoing	PIC Quarterly
5. Staff supervision	Agenda Form		X	100%	100%	Supervisors / HR Coordinator	HR Coordinator Monthly	PIC Quarterly
6. New Employee Orientation	Orientation Tool		X	100%	100%	Supervisors / HR Coordinator	Ongoing	PIC Quarterly
7. Monitor Staff Survey	Survey Tool		X	100%	100%	HR Coordinator	Annually	PIC / Board / Staff Annually

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West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Clinical Records / Health Information Management

Initiation Date: October 1, 2006 **Review/Revision Dates:** **September 30, 2009**

Purposes: Assure compliance with WAMH policy, DMH standards, MCD regulations, and HIPAA.

Action Steps: PI # 5

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Work with OM to maintain compliance with scheduling	Daily CMHC Schedule	X		100%	100%	OM	HIM Weekly	PIC Monthly
2. Monitor confidentiality of the organizational information system	Electronic transfer of information and documentation	X		BM HIM	TBD by BM and HIM	HIM BM	Ongoing	PIC as needed
2. Monitor consumer Records for retention and purging process	Administrative Review		X	Records to be purged at each site annually	80%	HIM / OM/C D	Ongoing	PIC Semi-annually
3. Monitor charts for Administrative Error rates	Review sheets		X	All records reviewed	100%	HIM	Ongoing	PIC monthly
4. Monitor MCD charts for corporate compliance	Charts and billing sheets	X	X	TBD by review schedule	TBD by review schedule	HIM CD BM	Ongoing	PIC Quarterly

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***Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.**

West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Substance Abuse and Prevention

Initiation Date: October 1, 2008 **Review/Revision Dates:** **September 30, 2009**

Purposes: Monitor and evaluate family involvement in SA program and success of prevention program.

Action Steps: PI # 6

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Monitor opportunities for family involvement in SA program	Group Schedule		X	Quarterly schedule	100%	Program Director	Clinical Director Quarterly	PIC Quarterly
2. Evaluate outcome measures of Prevention Program	Outcome measures		X	Science based programs	100%	Prevention Coordinator / Specialist	Program Director Monthly	Executive Director Program Director
3. Monitor number of consumers served by Prevention each month	Sign – in sheets		X	100%	100%	Prevention Coordinator	Program Director Monthly	E.D. County Commissions Quarterly
4. Monitor Environmental Campaigns monthly	Environmental Forms		X	100%	100%	Prevention Coordinator	Program Director Monthly	E.D. Program Director Monthly
5. Monitor meetings of Prevention Council	Minutes		X	100%	100%	Prevention Coordinator	Program Director Quarterly	E.D. Program Director Quarterly

A = Automated **M= Manual**

*Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.

West Alabama Mental Health Center
Performance Improvement Indicator

Indicator Name: Business Management

Initiation Date: October 1, 2006 **Review/Revision Dates:** **September 30, 2009**

Purposes: Monitor fiscal resources of the organization to support and improve the service delivery of WAMHC services. Maintain best practice standards with federal, state, DMH, and WAMH regulations, processes, and procedures for billing and fiscal management.

Action Steps: PI # 7

Performance Measure	Data Source/ Tool	A	M	Size of Sample	Threshold	Responsible Staff	Reviewed By & Frequency	Reported To & Frequency
1. Develop and monitor annual budget	Monthly financial reports, audits, cost reports, and analysis	X	X	All programs and services	All programs and services	ED and Business Manager	Administration Monthly, Ongoing	PIC Board Quarterly
2. Monitor MCD & state pay billing for accuracy	Electronic verification of billing accuracy	X		MCD & state pay billing	95%	AR Billing OM	Business Manager Monthly	Quarterly PIC Board as needed
3. Internal Compliance	Billing records and reconciliation with clinical records	X	X	TBD by CD and Business Manager	TBD	Business Manager Clinical Director	Business Manager Clinical Director Monthly	PIC as needed
4. Complete audits and cost reports as required	Business records & CPA	X	X	As required by CPA	100% accuracy	Business Manager CPA Administration	ED Business Manager Annually or as required	Board PIC DMH Annually
5. Quarterly reports on grant balances and crisis funding	Business records	X		All grants and crisis funding	100%	Business Manager.	PIC Quarterly	PIC Quarterly
6. Update D-Link	DMH Website	X		100%	100%	Billing	Clinical Director Monthly	PIC as needed

A = Automated **M= Manual**

***Highlight the Performance Measure on which you are reporting and attach the monthly / quarterly report to a copy of this sheet.**

West Alabama Mental Health Center

Substance Abuse Continuous Quality Improvement Plan 2009-2011

Introduction

The Outpatient Substance Abuse Program (SAP) at West Alabama Mental Health Center is designed to serve consumers with drugs or alcohol problems as they remain in a community setting. L.I.F.E. Tech consumers are paroled to the L.I.F.E. Tech campus while preparing to transition into their communities. Substance abuse services are available to all residents of the M-10 Catchment area and participants at the L.I.F.E. Tech Transitional Center who meet admission criteria established for the program.

A. Identify and encompass all program service areas and functions, including subcontracted consumer services.

The Outpatient Substance Abuse Program (SAP) at West Alabama Mental Health is designed to provide outpatient services to consumers with addiction problems as they remain in the community. These services are available to all residents of the M-10 Catchment area and participants at the L.I.F.E. Tech Transitional Center who meet current DSM criteria for substance abuse or dependence. Adult programs are available to individuals age nineteen (19) and above who meet admission criteria and do not fall into any exclusionary criteria.

Each IOP session meets for 2.0 hours per session. L.I.F.E. Tech conducts IOP 10 hours per week on average. Four IOP sessions are scheduled per week in Marengo County.

B. Substance Abuse Performance Improvement Plan and Program Description are presented for review and approval to the Board of Directors each year activated October 1, of the upcoming fiscal year.

The annual program description update will include program locations and is submitted to the West Alabama Mental Health Board of Directors annually for review and approval. Changes made to the program after Board approval are submitted to the Clinical Director for review. Program descriptions, policies and procedures are modified to reflect any approved changes.

The Substance Abuse and Prevention programs adhere to the overall Mission, Vision and Values of the West Alabama Mental Health Center as outlined in the Strategic Plan. The annual monitors and indicators for substance abuse, methodology for assessment, evaluation, implementation, and tracking of indicators and processes for communicating findings and documentation are all outlined in the Performance Improvement section of the Strategic Plan.

Reviews of Substance Abuse charts are scheduled monthly to review critical areas of compliance with DMH and agency standards. West Alabama Mental Health operates a risk management system as described in the Performance Improvement section of the Strategic Plan. All serious incidents are reported to DMH in accordance with outlined standards and submitted to the Executive Director or designee. Any issue requiring a Corrective Action Plan is reviewed by the Executive Director, the appropriate committee and evaluated by the Performance Improvement Committee (PIC) or an assigned task team for evaluation and action planning.

Reviews of monitors are recorded and reported on a monthly / quarterly basis to the Management of Information Committee (MIC) or the Performance Improvement Committee (PIC) and is reviewed annually by the Board. The Management of Information Committee outlines procedures for the review of clinical records, appropriateness of program admission, and Performance Improvement of the SAIOP program.

C. Substance Abuse Program Mission:

The mission of the West Alabama Mental Health Center's Outpatient Substance Abuse Program is to assist individuals in confronting their addiction and developing a plan for a drug-free lifestyle. The Outpatient Substance Abuse Program will accomplish this goal through an Intensive Outpatient Program (IOP), and Substance Abuse Outpatient Counseling (OP). These services allow for consumers to continue in their jobs or other responsibilities while receiving treatment within the community. For L.I.F.E. Tech consumers this allows them to attend GED instruction, classroom instruction, and trade school.

D. SACQIP contains the provider's goals and objectives related to PI:

West Alabama Mental Health advocates and utilizes the goals and objectives set forth by the Department of Mental Health Substance Abuse Services related to program improvement. These goals and objectives are outlined below.

Goals

- To focus on opportunities to improve direct services and direct care;
- To address problems identified that affect consumer outcomes;
- To disseminate information and obtain follow-up actions from appropriate committee(s), department(s), and all levels of staffing;
- To improve services by utilizing feedback from consumers, their families, and other organizations though annual surveys;
- To track a provider's performance over time to assure sustained improvements;
- To conduct self reviews designed to evaluate quality and appropriateness of substance abuse services.

Objectives

- Identify key functions and processes to be measured that will determine whether established standards of quality are being met or are exceeding the standards of care;
- Coordinate an annual quality review of Special Incident Reports and other reports from Advocacy. Facilitate the development of corrective action and recommendations for improvement to ensure improved care;
- Examine performance over time and utilize the information to improve services and outcomes;
- Promote consistent communication and collaboration among service providers.

E. Responsibilities associated with the Substance Abuse Performance Improvement Plan:

The Substance Program Director will coordinate the SACPIP. The Performance Improvement Committee (PIC) is responsible for coordinating the program improvement system. The organization of the PIC activities is outlined below.

- Identify key functions and processes that will be measured to determine if established standards of quality are met or exceeded by Substance Abuse (SA) Services;
- Define PI Indicators necessary to measure the SA program's performance in achieving desired outcomes for consumer services;
- Report, investigate, review, and identify corrective action when needed to address special incidents involving consumers;
- Develop a Consumer/Family Satisfaction Survey designed to gain input from consumers and their families regarding issues which impact the quality of care and treatment;
- Review the treatment planning process assuring that consumers are involved in the development of the plan and that needs are being met;
- Review site visit reports to extract significant deficiencies in order to provide needed technical assistance;
- Facilitate the development of recommendations and actions, including but not limited to changes in policies/procedures;
- Review the Substance Abuse Program Improvement Plan annually.

F. West Alabama Mental Health's Strategic Plan includes the methodology for assessment, evaluation, and implementation of improvement strategies for important processes and outcomes

Based upon recommendations made by the PIC committee and following the DMH site review, performance measures are formulated. These performance measures

are evaluated monthly / quarterly, and annually by MIC (Management of Information Committee). Reports of findings are then made to the PIC. The Substance Abuse Director, Clinical Director, and program staff is tasked with implementation and completion of the improvement strategies.

G. The Organizational Strategic Plan for FY 2009-2011 provides for identification and monitoring of important processes and outcomes for the five components of Performance Improvement: Quality Assurance, Quality Improvement, Incident Prevention and Management, Consumer and Family Satisfaction, and Treatment Plan reviews consistent with the definitions found in the SASD Standards.

Quality Assurance – Following site reviews, an action plan is formulated by the SA Program Director, Clinical Director and Executive Director. This plan outlines the implementation of strategies designed to promote program improvement. A Performance Improvement Plan is generated based upon this action plan and other targeted standards. The Performance Improvement Plan monitors are reviewed by MIC and revised annually by the Substance Abuse Director. Active records are reviewed quarterly by the Clinical Director or Program Director and the Health Information Manager. The review process includes monitoring treatment plans, medication forms, progress notes, releases, consent for follow-up and any other critical items such as admission criteria. Deficiencies are indicated on the Clinical Review Form and providers have one month to remove identified deficiencies when records are reviewed again.

Quality Improvement – Incident Prevention and Management – West Alabama Mental Health has written policies and procedures regarding the identification and reporting of special incidents involving consumers. Incident/Accident reports are reviewed by The Executive Director who then determines the avenue for resolution. All serious incidents must be reported to the Executive Director or designee within 24 hours. Agency policies and procedures are in accordance with written standards and procedures published by DMH and SASD. Timely and adequate investigations are conducted as per written policies; all reported incidents are reviewed on a daily basis.

Consumer and Family Satisfaction – Follow-up letters are mailed to consumers within ninety days of termination regarding satisfaction with services provided and inquiring as to whether the consumer needs additional services. Suggestion boxes are placed in each facility for consumers to offer input at all times. WAMHC utilizes periodic surveys of all board programs to collect quality of life and quality of service data. All policies and procedures ensure that the confidentiality of consumers and their families are maintained as required by HIPAA.

Treatment Plan Review – Another component of the SACPIP process is an ongoing review of the treatment plan that is incorporated into the consumer record. Treatment

plans are recovery-oriented and reflect the unique needs of each individual consumer. Treatment plans are reviewed quarterly for quality assurance.

H. Specify the manner in which communication of PI findings and recommendations, for all PI components; occur at the governing body level, and the manner in which this process is documented.

Quarterly updates are presented to the Board of Directors at their monthly meetings; an end of year review is completed at the September meeting of the WAMHC Board. Before this meeting the members of the board receive, via United States postal mail, the Strategic Plan for the next two fiscal years. The drafted SACPIP is sent ahead of time to provide an opportunity for the Board of Directors to review the proposed plan prior to that September meeting. This ensures that each member is given an opportunity to provide feedback and make suggestions to the SACQIP. During the meeting, after any corrections or suggestions have been made, Board members vote to accept or reject the SACQIP.

At this same meeting the Board and WAMHC staff members who are present also discuss the review of the previous year's quality assurance monitors and indicators. Monthly / quarterly reviews are documented on agenda forms and minutes are kept in the appropriate binders for review.

West Alabama Mental Health Center
MANAGEMENT OF INFORMATION PLAN 2008-2011

INTRODUCTION

The West Alabama Mental Health Board recognizes that the delivery of mental health services is a complex endeavor that is highly dependent on information. The mental health center depends on the effective and efficient management of information concerning the individuals served, the services that are provided to those individuals, the results of the care provided, and in the center's performance. The entire organization is dependent upon the mental health center's information system for monitoring programs and services, billing, communication, and in providing services to their consumers or stakeholders. In many cases, external stakeholders (DMH, Medicaid, Medicare, EAP's, etc.) dictate what information is collected, how the information is transmitted and utilized.

The mental health center's current information system was developed as a reaction to the needs and requirements of external sources such as DMH and Medicaid. The reason for the development of our current information systems upon these two external sources is simple. DMH is a primary funding source and certifies programs operated by the mental health center. Over the past sixteen years, Medicaid has become the most important funding source for the center and clinical, business, and management information has been developed to meet the needs of this organization. Clinical and administrative decision making, and data collection has been entirely focused on the needs of external sources. Internal decisions, such as computer selection, computer software selection, clinical database organization, record keeping, and transmission of data have been based on the needs and requirements of these external sources.

Many information systems have been fragmented by the different requirements of external sources. This is particularly evident in the development of different clinical forms for the different programs operated by the mental health center. Over the years, internal cultural forces and external requirements have produced different chart formats for the various service programs, i.e., substance abuse, ID/DD, outpatient MI, and MI Day Programs. Many of the administrative forms and procedures have been consistent within service programs but intake/assessment forms, progress note documentation, and treatment-planning documents (plan of care) vary to some degree. In some cases, the same service program, case management, has been required to use different forms and procedures by external sources.

Only recently has this issue received any attention on a statewide basis. In 1997, the Alabama Council of Community Mental Health Boards (ACCMHB) in conjunction with MTM Services began a process to address this issue through the Operations Enhancement Initiatives (OEI). This process was designed to promote the development of a statewide system of mental health care through the delivery of services in a similar manner and by promoting the exchange of information between providers in a consistent manner. The OEI process had mixed results statewide but certainly had a

major impact particularly on the consistency within mental health centers and between mental health centers on MI outpatient and day program documentation. The Alabama Council deserves recognition for identifying these issues and taking proactive steps toward resolving these issues internally with little or no support from external sources particularly the Alabama Department of Mental Health and Mental Retardation. Internally, the management team of West Alabama Mental Health developed a single chart format for all WAMHC programs. The single chart format goal was completed in the FY 2004 – 2005.

Funding restricts the development of a comprehensive management of information system at the mental health center. West Alabama Mental Health Center (WAMHC) is a relatively small organization that provides services in a rural and economically depressed and disadvantaged section of the State of Alabama and the nation. WAMHC is not unique in this regard as most community mental health centers in the state have at least one county that is rural and/or economically disadvantaged. However, WAMHC is probably unique in that the M-10 catchment area does not have a significant metropolitan area within its five county area (Demopolis is the largest "city" with a population of approximately 8,000). Although the budget has grown to more than four million dollars in recent years, the mental health center rarely has the ability to budget substantial amounts of funds to expand non-revenue producing cost centers such as the expansion of management of information systems. Therefore, improvements in the WAMHC management of information systems, such as software purchases, computer updates, and automation in general, must be done incrementally as funding becomes available.

As mentioned earlier, the development of an information system at the mental health center has depended upon the requirements of external stakeholders and sources. Leadership has reacted to requirements of these external sources with little internal planning and development with the exception of meeting DMH and third-party payer requirements. However, the leadership of the mental health center has viewed the OEI process and the accreditation training process as an opportunity to become more active in: (1) the development of consistent and effective data collection system; (2) improve the center's ability to analyze that data and use it in the management process; and (3) improve the organization's ability to transmit, report, and share this information internally and externally.

The responsibility to develop this process rests clearly with the leadership of the mental health center. The development of a management of information plan is seen as an initial step forward in achieving this goal. It seems obvious that a proactive approach to data collection - information development - and information management will enable the mental health center to more adequately meet the needs of external stakeholders while promoting a more effective system of clinical care and more efficient management of the organization

Expected Outcomes and Goals

The ultimate goal of any management of information plan is to collect, manage, and use information to improve organizational performance in: (1) care and service delivery; (2) management of the mental health center; (3) meeting the internal and external needs of the mental health center. To meet this goal, the mental health center must be able to meet the organization's internal and external informational needs. Key information management processes are noted below:

- Identifying the information needs of internal and external stakeholders,
- Developing and designing an information management structure at the mental health center,
- Developing the ability to identify and record/collect data useful to the management of the mental health center and to meet the needs of external payers, accreditation sources, and other external stakeholders,
- Developing the capability of analyzing the data collected and transforming that data into information used for management and decision making at the mental health center,
- Exhibiting the capability to send that information appropriately (transmit) and report the data and information collected in a timely and effective manner meeting the needs of the mental health center and external customers and stakeholders,
- Exhibit the ability to integrate and utilize the information collected in the management process of the mental health center.

The mental health center must develop and maintain a system to not only collect data needed for management; but a system that takes that data and transforms it into information that can be used to make informed management decisions. The management of information system must be responsive to external needs and be able to provide data to external and internal sources in a timely and efficient manner. This must involve a continuously improving information management process, which involves:

- The development of a system that promotes timely access to information throughout the organization,
- Continuously explore ways to improve the accuracy of the data collected,
- Developing and evaluating the requirements of confidentiality and security of information with ease of access to that information for the mental health center,
- Promoting the development of a system which uses aggregate and comparative data to produce information needed in the management of the mental health center,
- Evaluating, accessing, improving and when necessary re-designing information-related processes to improve the efficiency of data collection,
- Increase the sharing of information internally (between programs and committees) and externally (with other community mental health centers and external stakeholders) to enhance individual care and the delivery of services.

The common denominator in the development of an effective management of

information system is the data and eventually the information produced by the process. This has resulted in the mental health center providing data to external sources and being dependent upon these sources to provide feedback such as DMH Statistical Manuals. The mental health center recognizes the necessity for compliance with the needs of these external customers/stakeholders with whom we are tied by common goals and services.

The mental health center has utilized knowledge-based information in the development of some programs and management processes. The use of Internet services to obtain knowledge-based information has become more commonplace and the mental health center continues to utilize and expand this resource for staff as funding becomes available.

The mental health center has utilized some comparative data and information in the past. However, this usually involves the use of information provided by DMH through Statistical Reports, utilization summaries such as IDP Program expenditures, and state hospital utilization reports. The Alabama Council and individual members have also provided comparative information that has been used to make management decisions. West Alabama Mental Health Center will cooperate in the development and use of comparative performance data and information, which will be used in the management of the organization.

These processes will include:

- The development and management of individual specific data and information,
- The development and use of aggregate data and information in the management process,
- The development and utilization of expert knowledge-based information in clinical service development and management in general,
- The development and use of comparative performance data and information.

In discussing management of information, it is important to define the terms used in the process. Key terms and definitions in the management of information process are noted below:

- **Information:** an interpreted set or sets of data; organized data that provide a basis for decision-making.
- **Data:** uninterrupted observations or facts.
- **Capture:** acquisition or recording of data and information.
- **Transformation:** the process of changing the form of data representations; for example, changing data into information by using decision-analysis tools.
- **Transmission:** the sending of data or information from one location to another location.
- **Function:** a goal-directed, interrelated series of processes such as assessment or care.
- **Security:** protection of data from intentional or unintentional destruction,

modification, or disclosure.

- **Aggregate:** to combine standardized data and information.
- **Knowledge-based information:** a collection of stored facts, models, and information that can be used for designing and redesigning processes and for problem solving. In the context of this plan, knowledge-based information is found in the clinical, scientific, and management literature.
- **Care:** includes care treatment, services, rehabilitation, habilitation, or another program instituted for the individual served.

Committee Structure and Management of Information Process

The committee structure of West Alabama Mental Health Center is also discussed in the Strategic Plan as well as in **Appendix B**. One of the primary responsibilities of the Performance Improvement Committee is to ensure that data is converted into information, which is used to manage the organization. This is accomplished not only through the establishment of a Strategic Plan, Performance Improvement Plan, and Management of Information Plan but through the process of continuous quality improvement as promoted through the committee structure itself.

Committees may use decision -analysis tools like cost analysis, process mapping, cause and effect diagrams, Pareto charts, scatter diagrams, histograms, run charts, control charts, and trending. After collecting the data and using these decision-analysis tools to convert the data to information, the committees will send periodic reports to the Performance Improvement Committee for review.

Development of the Management of Information Plan

The Performance Improvement Committee reviews and revises the Management of Information Plan annually. The Management of Information Committee, the Health and Safety Committee, and the Human Resources Committee will make input concerning monitoring activities. Monitoring activities will be driven by the Mission-Vision-and Guiding Principles of the mental health center and will support the goals and objectives as stated in the Strategic Plan. The Performance Improvement Committee will review and approve the monitoring activities of each committee. This ensures that the leadership of the organization is responsible for the approval of the monitoring activities of the mental health center. Each committee will develop tools to collect the information for each monitor. Input from stakeholders such as consumers and families will be obtained through meetings, surveys and annual meetings.

Training

WAMHC committee members will receive training in Continuous Quality Improvement (CQI) terminology and processes, in using tools for generating ideas, in using tools for making decisions, in using tools for analyzing problems, and in using tools for analyzing data **(see Appendix A)**. In addition to communicating the plan to all staff, Program Directors and committee members will meet each year after the Management of

Information Plan is approved for training on the data collection tools for each monitoring activity. Committees may also receive specific training to promote committee member understanding of the issues related to their monitoring. For example, Health and Safety Committee may feel that H&S Officers need training on rules related to facility operation.

Information Management

West Alabama Mental Health Center recognizes that the management of information is critical to providing, coordinating, and integrating effective care and services. This information is maintained and utilized through four interrelated processes: (1) clinical data and information, (2) financial data (business/billing/consumer database activities), (3) human resource data, (4) administrative data and information activities. All of these activities are critical to the overall delivery of services and management of the mental health center.

Stakeholders

Information obtained from stakeholders, particularly consumer and family input, is considered a priority of the management of information process. Information will be obtained from consumers, family members, staff, the community, and other stakeholders in the following ways:

- Suggestions and recommendations from the Consumer and family advisory groups,
- Suggestions from staff, consumers, and others through suggestion boxes placed in each facility operated by the mental health center,
- WAMHC referral source surveys, which will be conducted annually,
- DMH **Consumer Satisfaction Surveys** are distributed to a percentage of mental health center consumers periodically. The surveys are currently reviewed and tabulated by the University of Alabama, the results of the survey are then returned to the mental health center for review.
- DMH **Consumer Quality of Life Surveys** are distributed to the same consumers participating in the Consumer Satisfaction Survey noted above. The tabulation and results are handled in the same manner.
- DMH **Family Satisfaction Surveys are** distributed to family members of the consumers receiving the Consumer Satisfaction Survey and Quality of Life Survey with their written consent. The survey is tabulated and returned as noted above.
- The Staff Advisory Group will conduct a Staff Satisfaction Survey annually. This information will be collected and tabulated by that group before review by the Performance Improvement Committee then submitted to the Board for review and then distributed to staff.
- Group meetings to discuss mental health center activities are designed to receive feedback and suggestions from the community on services provided by the mental health center or services needed/requested by the community.
- Complaints, grievances, and other feedback from any stakeholder.

This information will be reviewed by the WAMHC committee structure in their monitoring activities and to identify areas, which may need planning or corrective action. Most of this information, suggestions from the Consumer and Family Advisory groups, recommendations from the suggestion boxes, the Community Survey, Consumer Satisfaction & Quality of Life Survey, the Family Satisfaction Survey, and information from interagency meetings, will be collected by the Executive Director (or designee) and analyzed by the Performance Improvement Committee. This committee will organize the data and using CQI tools will analyze the data to use as information to make recommendations to the Board, take corrective action, and so on. Executive Director (or designee) will maintain this information in binders/files. Complaints, grievances and other feedback will go directly to the Executive Director for review and to determine the appropriate procedure for handling the feedback. This will be done using the Corrective Action Format discussed in the Performance Improvement Plan. Because of the sensitive and often confidential nature of this information, the Executive Director will report findings to the PIC and Board as needed. The information will be maintained by the Executive Director (or designee).

Clinical Data:

Management of clinical or consumer information is the responsibility of the Management of Information Committee. This committee is responsible for the review and approval of all clinical forms used in WAMHC consumer records. This committee is also responsible for management issues concerning the consumer record such as confidentiality, security, HIPAA compliance and access.

The Consumer Record:

The consumer record contains information critical to the management of each individual's care and documentation for billing. As mentioned earlier, due to external requirements and internal cultural factors the forms used are not entirely consistent between the Mental Illness, Substance Abuse, and Mental Retardation programs operated by the mental health center. However, through the efforts of the Council's OEI Process some of these barriers have been addressed. A goal of the management of information process is to become consistent across all programs in the use of forms such as the assessment tool, plan of care, and progress report/note.

Currently, all forms and operational descriptions for the Consumer Record are contained in the WAMHC Quality Assurance (QA) Manual. This manual contains a copy of each form and an operational description of the use of the form used in all programs (see QA Manual). The QA Manual is divided into eight sections, which correspond to the single chart format.

The Consumer Record is divided into eight sections. The eight sections of the Consumer Record and the forms contained in each section are as follows:

Consumer Record Sections:

(1) File Index	Client Identification Sheet Emergency Information Form Daily Attendance Record Copy of Insurance Card(s) Residential Financial/Room & Board Agreement Residential Financial Exemption Status Proof of Income Legal Guardianship Papers Copy of Single Chart File Index
(2) Progress Notes	Consumer Case Tracking Form Utilization Review Progress Note & Service Ticket Quarterly Status Report CMP/POC Narrative Bi-Weekly Progress Report Progress Report(s)-(other providers, ID Case Summary, miscellaneous)
(3) Plan of Care	Support Team Announcement Temporary Plan of Care (POC) Person-Centered Plan of Care (PC-POC) Active Treatment Profiles (ATP) Medicaid Waiver Plan of Care Plan of Care Training Agenda Individual Support Plan Behavior Support Plan/Target Behavior Documents Service Education Plan Treatment Plan Review Summary Outpatient Plan of Care Case Management Plan of Care
(4) Assessments	Face Sheet Referral Form SAI Forms (A-F) Psychosocial Assessment (Adult/ Adolescent) Individual/Family History Form Psychological Assessment/Update ICAP Computer Scoring Report ICAP (Inventory for Client and Agency Planning) SUN-R Assessment/Reassessment DMH Criticality Information Summary Eligibility Worksheet (ID and Living-at

	Home Waivers) Self-Medication Assessment Human Services Needs Assessment (HSNA)/Reassessment Questionnaires Level of Functioning Assessment A&B Medicaid Waiver LTC-2 Form Medicaid Waiver IDDD-4 ICF/ID Level of Care Evaluation Summary Program of Habilitation Orientation/Admission Checklist LEA/Education Certification Prior Authorization Request Form Miscellaneous Assessments
(5) Releases/Consents	Consumer Handbook Release Authorization Notice of Privacy Practices (HIPPA Release) Consent for Follow-up Form Authorization for Releases of Consumer Information Durable Power of Attorney for Healthcare Consent to Manage Consumer's Personal Funds IOP Contract Certificate of Choice Dissatisfaction of Service Emergency/Medical/Transportation Authorizations Request for Interagency Transfer
(6) Health/Medical	Provider Medication Chart & Drug Usage Profile OTC/Other Provider Medications TMAP (Green Sheet) Clinic Referral Form Psychiatric Assessment Progress Note Prescription Slips Psychotropic Medication Release Medication Informed Consent Log Nursing Progress Notes Laboratory Consultation Form/ Lab Reports AIMS Assessment Comprehensive Physical Examination Medical Needs Review Communicable Disease Statement Immunization Record

Communicable Disease Statement
Immunization Record
Consultation Request Report
Physicians Standing Orders
Seizure Chart
Blood Pressure Chart
Blood Sugar Level Chart
Weight Chart
Indigent Drug Program (IDP)
Information Form
Prior Authorization Request Form-Medical
PAP Approvals/Denials
IDP/PAP Medication Slips
Miscellaneous Health/Medical

(7) Discharge Summaries

Discharge Summaries
Denial of Admission to Services

(8) Miscellaneous/Correspondences

Correspondences (coming-in; going-out) etc.

Consumer Records will contain the following information:

- Information to identify the individual, support the diagnosis, justify treatment, document the course and results of treatment, and document the facilitation of care to other providers.
  - The individual's name, case number, home address, date of birth, sex, race/ethnicity, next of kin, education, marital status, employment, home telephone number, social security number, referral source, reason for referral, date of admission to the program, admission type, and other legal and demographic information is found on the Assessment/Intake Form.
  - Discharge summaries, medical information, and other reports are obtained as needed after obtaining a signed release from the consumer. This information is filed in the discharge or assessment section of the Consumer Record.
  - The Assessment/Intake Form includes information on the individual's: presenting complaint/reason for admission; medical history; legal history; family history; educational history; employment/vocational history; prior psychological/psychiatric history; military history; alcohol/drug history; and mental status examination. The Assessment/Intake will contain a statement of conclusions to support the need for treatment, and the diagnoses or diagnostic impression.
  - The Plan of Care or Treatment Plan will: identify the clinical issues that will be the focus of treatment; with input of the consumer specify services that will

best meet the consumer's needs; include referrals appropriate for services needed but not provided by the mental health center; identify the expected outcomes toward which services should be working; is approved by an appropriately licensed staff member. The Plan of Care is reviewed and updated to conform to appropriate standards. Quarterly Plan of Care reviews are documented on a Treatment Plan Review Summary by a licensed clinician.

- The Plan of Care will contain the diagnosis, which will be approved by either a medical doctor, a licensed psychologist, or certified registered nurse practitioner.
- The Plan of Care must have the consumer's signature or when appropriate the parent or legal guardian's signature to promote involvement in the treatment process.
- Evidence of known advance directives will be indicated for all residential, (group home, foster home, supportive apartment), and rehabilitative day program consumers.
- Progress reports document the consumer's progress toward the goals and objectives noted on the Plan of Care. Written progress reports are noted for each outpatient contact: at least bi-weekly progress reports for rehabilitative day treatment programs along with daily attendance/activity logs; and at least semi-monthly for residential consumers. These reports should include clinical observations, the consumer's response to care and services provided. In addition each POC goal should be rated according to progress made at that point in time.
- Written progress reports should document consultation contacts, and any referrals or communication with internal or external care providers.
- Informed consent is obtained prior to participation in research projects, when special therapeutic techniques (audio/visual recording, two-way mirrors, etc.) are utilized, or when procedures might place an individual at risk or cause an unusual reaction such as pain.
- Release Authorization (consent) forms are obtained for each instance of disclosure in which information concerning the identity, diagnosis, prognosis, treatment, or case management of the consumer is disclosed. The consent form must include: the name of the programs making the disclosure; the name or title of the person or organization to which the disclosure is being made; the purpose for the disclosure; the specific purpose or need for the disclosure; the extent or nature of the information to be disclosed; a statement that the consent is subject to revocation by the consumer or his/her agent at any time except to the extent that action has been taken; a specification of the date, event, or condition upon which the consent will expire (no more than one year); the date on which the consent was signed; and the signature of the consumer or agent and a witness.
- Each consumer will receive an informational handbook with individual rights and responsibilities. A release form is signed by the consumer to document that they received the handbook and that the handbook was reviewed with them.

- A Medication Chart listing all medication (psychotropic, non-psychotropic, provider prescription, other physician prescription, and non-prescription/over-the-counter) reported by the consumer at intake and an ongoing account of prescription and non-prescription medications taken by the consumer during the course of treatment. For medication prescribed by a mental health center psychiatrist, the medication chart must contain the name, strength and dosage of the drugs, the date prescribed, the number of refills permitted, and the prescribing physician's name. When an authorized staff member administers medication, the dose must be noted on the Medication Chart.
- A Corrective Action Plan will be placed in the Consumer Record for any unusual occurrence such as: treatment complications, accidents or injuries that occur while under the mental health center's care, morbidity, and the individual's death.
- A Discharge Summary is required for each consumer after services are discontinued for any reason, i.e., services are completed, death of the consumer, the consumer discontinues treatment, etc. The Discharge Summary will be filed in the Consumer Record on top of the most recent progress note. The Discharge Summary will explain the reason for termination of services.
- Transfer Summaries are completed when a consumer's care is changed to a different program at the mental health center. When the individual is transferred, a Transfer Summary must be completed as soon as possible after notification of the change. The Transfer Summary will include information regarding the program in which the consumer was attending and the program to which they are going as well as the reason for the transfer.
- Verbal orders are accepted and transcribed by either a nurse or pharmacist and noted in the clinical record on a progress note. Verbal orders for medication must be signed by the prescribing physician within seven days.
- Clinical information is entered into the Consumer Record in a timely manner as specified by each clinical form. All entries in the record are signed with credentials or title and dated by the staff member responsible for making the entry.
  (Refer to the QAC Manual for a complete description of the chart format and to review the current clinical forms for each program.)

Confidentiality and Security. Confidentiality and security of the Consumer Record is a priority of the mental health center. All Consumer Records are maintained in a confidential and secure manner as indicated in GC - 5.3 in the WAMHC Policy and Procedure Manual. All open Consumer Records are maintained in the office where they receive services. The records are kept in filing cabinets and are at least "double locked" to prevent unauthorized access. Double locked essentially means there are at least two locks, i.e. a locked door and a lock on the filing cabinet, which prevent unauthorized access to the records. Some closed records are maintained in boxes or file cabinets, which are secured as noted above.

Closed records are maintained for at least ten years in accordance with GC-13. Because

of space limitations, closed Consumer Records may be destroyed following the guidelines established in GC-14. Because of the long term nature of treating seriously mentally ill individuals, there are often several volumes of a Consumer Record for any given individual. These records may be purged from time to time according to GC-14.

West Alabama Mental Health Center operates programs in multiple counties and at multiple sites. Therefore, Consumer Records must often be transported from one site or county office to another office or site. Confidentiality is maintained by enclosing the Consumer Record in a secure vinyl envelope. When transporting records, staff members should place the vinyl envelope in a secure place in the vehicle, e.g., the trunk of a car or storage area of a van.

Records may be released to outside organizations as indicated in GC-5.3 when appropriate authorization has been obtained from the consumer. Organizations that reimburse for payment of services have the right to audit or medically review records for appropriateness of service. When records are audited by outside agencies, the audit will be done on site and in a confidential manner. When mailing records, only information pertinent to the release should be sent and the information should be stamped "confidential." Consumers are informed of this release of information when their case is opened at the mental health center through a Statement of Understanding. All consumers are also informed of their rights and responsibilities at the time of assessment/intake as they are given a Client Rights as a part of the Consumer Handbook.

Access to the Consumer Record is limited to authorized individuals as indicated in GC-5.3. In general only those staff members responsible for the following will have access to and be allowed to make notations in the Consumer Record: (1) direct service care of the individual, i.e. the psychiatrist, therapists/counselor, case manager, etc.; (2) medical records coordination; and (3) supervision of the direct service staff member or approval of documentation. An Employee Signature Card will be obtained for each employee and maintained as specified. A copy of the signature card will be maintained in: (1) the Medical Records Department in the main center office. Each staff member will be given a copy of his or her signature card. If an employee's name or credentials change, they are responsible for contacting the Human Resources Office and executing a new signature card.

Audits. Information obtained from the record is audited or reviewed periodically for compliance with various standards. Consumer demographic information is regularly reported to DMH for statistical purposes. Other information from the record is used to support contract compliance with DMH in such areas as discharge follow-up from state hospitals, and suspected or reported abuse or neglect.

Quality Assurance Reviews are conducted regularly as part of the QAC Program and to meet DMH compliance. These reviews have consisted of administrative and clinical reviews of record documentation and compliance. Approximately 10% of all open records are reviewed each month during staffing. New records and closed records are

reviewed on a monthly basis as needed. A quarterly report is submitted to the Board about these activities. A Utilization Review is conducted on admissions to the residential program to assess the agency's compliance with LOS expectations and will determine and implement actions to improve performance when variations in LOS expectations occur. Administrative reviews assess the appropriateness of admission to programs relative to published admission criteria the program description. Staff meetings focus on treatment plan compliance and clinical treatment issues.

The Quality Assurance Review process currently in place meets all DMH requirements. Consistent feedback is reported to clinical staff concerning their documentation after each staffing. The monthly staffing process addresses quality assurance issues. Ten percent of the charts staffed each month are reviewed for internal compliance as well as compliance with standards regarding treatment plans and other issues. By reviewing a percentage of each direct service staff member records each month documentation issues or problems may be identified and corrected before they become a major issue. Direct service staff will receive frequent and consistent feedback. It will also be easier to determine documentation-training needs for staff.

When an error is found in a Consumer Record a Review Form is completed and given to the direct service staff responsible for this record. The appropriate staff member will correct any problems or deficiencies noted on the form within one month. The staff person will note the correction with their initials and indicate the date that the problem/deficiency was corrected. The Quality Assurance Review Form is then given to the direct staff person's supervisor. The supervisor will verify that the correction has been made and sign the bottom of the form before giving the form to the Clinical Director. The Clinical Director maintains the review forms in a binder to support follow-up on corrective action. Serious problems with compliance with documentation standards may result in a Corrective Action Plan recommendation and disciplinary action.

Financial Information.

The West Alabama Mental Health Center Business/Billing Department maintains the consumers' database, submits billing claims and vouchers, pays all bills, handles the payroll, and maintains and updates the financial programs. The Business/Billing Department also assists the mental health center's accountant with the annual audit and cost reports. Business information such as accounts receivable, accounts payable, and the general ledger are computerized and maintained with CMHC software (contract with CMHC Systems). Technical support is provided through a support contract with CMHC Systems. Billing is submitted electronically on software provided by the payer. The consumer database and business/billing information is maintained on a computer located in the billing department. Security of this system is maintained through a system of user IDs and passwords. The user IDs and passwords determine what programs any particular individual has access to and limits the ability to view, enter, delete, and/or change information.

The Business/Billing Department produces a number of standard reports each month. Some of the standard monthly reports include the following: the monthly financial summary report, clinical service reports, quarterly staffing reports, productivity reports, and billing error and correction reports. Committees involved in the management and administration of the mental health center may request reports or information for monitoring, grants, or other purposes. The Executive Director or Assistant Director or designee may approve the release of information immediately, or take the request to the PIC committee for feedback.

The data maintained by the Business/Billing Department is essential to the operation and management of the mental health center. The manner in which this data is used in the monitoring process and management of information system is crucial to the continuous quality improvement efforts of the staff and leadership of the organization.

(For specific Policies related to confidentiality and security of business/billing information refer to the Business Section of the Policy Manual).

Administrative Information

Another source of information essential to the management of the mental health center is information which is produced internally and externally and flows into and through the mental health center from numerous sources. Administrative Information flows through the office of the Executive Director for review before dissemination to other staff members. Much of this information is produced internally and must often be approved by the Board before implementation. Other information of this type may go directly to the Assistant Director, Business Manager, Clinical Director or other management level staff member before it is directed to other staff members. This information includes the following information:

- Contracts and Agreements
- Standards Manuals
- Billing Manuals
- Medicare/Medicaid Regulation Manuals
- Policies and Procedures
- Program Descriptions
- Site Visit/Accreditation/Audit Reports
- DMH Correspondence
- Medicare and Medicaid Newsletters
- Alabama Council Correspondence
- Informational Newsletters, Articles, and Journals
- Workshop and Training Information
- Pamphlets, Newspaper Articles, and other Public Relations Information about the MHC

DMH and Alabama Council Correspondence. The Executive Director will review all DMH and Alabama Council correspondence prior to distribution to staff members. The original copies of this correspondence will be maintained in locked files, which will be organized by the Executive Assistant. When purging correspondence, only correspondence related to certification, pertinent billing issues, or of historical significance to the mental health center will be kept. The Executive Director will distribute copies of pertinent correspondence to Program Directors as deemed appropriate. This information may be distributed immediately or at the PIC meeting each month depending on the need for distribution. Program Directors may make copies of correspondence for staff members unless the Executive Director specifically restricts this.

Contracts and Agreements. Contracts are reviewed and executed by the Executive Director as designated by the Board. The Business Manager, or designee, and Program Director, whose program is affected by the contract, may be asked to review the contract prior to execution at the discretion of the Executive Director. The original copy of a contract will be maintained in binders provided for each program operated by the Board. The Executive Assistant will maintain these binders. No additional copies of any contract will be made unless approved by the Executive Director.

Medicare, Medicaid, and Other Billing Information/Newsletters. The billing office will maintain all billing newsletters, such as the Medicare Focus newsletter. In most cases, there are multiple copies of these newsletters and the information often impacts not only the business/billing department but direct services as well. The Executive Director and Clinical Director will review these newsletters. The Management of Information Committee (MIC) will be responsible for advising the Executive Director and Performance Improvement Committee (PIC) and utilizing the information contained in these newsletters. For example, the *Medicare Focus* newsletter has an article pertinent for partial hospitalization services. The MIC will review this information and determine how to address the issue in the provision of the service or in the billing mechanism. The Clinical Director will take this information to the PIC for discussion and approval. In cases where immediate action is needed, the Executive Director, Assistant Director, Clinical Director and Business/Billing Department may make an immediate decision to implement the recommendation. The Executive Director will then report this information to PIC at the next meeting. The Business/Billing Department will maintain all billing newsletters for at least five years. When purging these newsletters only those newsletters with historically significant information will be maintained.

Policies and Procedures. Board approval of the separation of Policy statements and Procedure statements was accomplished in 2007. The WAMHC Policy Manual will now be reviewed and approved by the Board and the WAMHC Procedural Manual will be reviewed and updated by the Performance Improvement Committee. This change also enhances the delineation of administrative responsibility with the Board clearly responsible for establishing WAMHC policy and the leadership of the organization clearly

responsible for the operational procedures of the organization.

The "original copy" Policy Manual and Operational Procedure Manual will be maintained at the administrative office of the mental health center. The Executive Assistant will be responsible for maintaining these manuals and ensuring that up-to-date copies of the manual are appropriately distributed. Up-to-date copies of the Policy Manual and Operational Procedure Manual will be given to the Executive Director, Assistant Director, Business Manager, Clinical Director. There will be an updated copy of each manual in each location operated by the Board so that all employees have access to the manuals. These manuals are considered the property of the Board and may not be reproduced for any reason without the written permission of the Executive Director as approved by the Board's attorney.

The Executive Assistant will also maintain a "historical copy" of the Policy Manual and Operational Procedure Manual. These manuals will include copies of all policies and procedures including the revised copies for historical reference. When a policy or procedure is changed, the Executive Assistant will distribute copies of the new policy and procedure to the appropriate sources and will collect copies of the old policy or procedure. With the exception of the copy retained in the "historical manual," all other copies of the replaced policy or procedure will be destroyed.

Standards Manuals and Billing Manuals. DMH Standards Manuals and Billing Manuals of various sources are key sources of information for the provision of appropriate services. The Executive Assistant will maintain an original copy of these manuals. Copies of these manuals will be given to the Executive Director, Assistant Director, Business Manager, Clinical Director, and Program Directors. A Copy of each manual will be maintained in each facility operated by the Board. Medicaid and Medicare regulation manuals will only be maintained in the administrative office. The Executive Assistant will maintain a historical file with copies of current and previous manuals related to standards and billing compliance and regulations. When a standard or billing manual is changed or updated, the Executive Assistant will distribute copies of the "updated manuals" too appropriate staff and collect copies of the manual, which have been replaced. With the exception of the "historical copy" all other copies of the manuals will be destroyed.

Program Descriptions. The Board approves Program Descriptions annually after review by the PIC. Program Descriptions are maintained in a manual, which is kept in the administrative office of the mental health center. The Clinical Director is responsible for the development and update of the Program Descriptions. The Clinical Director reviews the program descriptions then presents updates to the PIC. After approval by PIC, the Programs Descriptions are sent to the appropriate office or service area at DMH for review if a new plan. After this is completed, the Program Descriptions are presented to the Board for approval. The PIC reviews Program Descriptions each year for Board approval; the Executive Assistant maintains a copy of the manual categorized by program type. The Executive Assistant is responsible for distributing copies of the manual to the Executive Director, Assistant Director, Business Manager, Clinical

Director, and each Program Director. Copies of the Program Description Manual are placed in each facility operated by the Board. This information is considered the property of the Board and may not be copied or reproduced in any way without the written approval of the Executive Director.

Site Visit, Accreditation, and Audit Reports. Reports concerning certification and accreditation will be sent to the Board President and Executive Director. Appropriate administrative and clinical staff members will develop responses to these reports. The Executive Director, Assistant Director and Clinical Director have overall responsibility for the certification/accreditation response although Program Directors may be responsible for or assigned much of the responsibility for composing the response. All responses to site visits will go to the PIC for review and to the Board for approval. After approval, the Executive Director will send the response with an appropriate cover letter signed by the Executive Director, Assistant Director, Clinical Director, and appropriate Program Director. Certification and Accreditation Reports will be labeled by the name, date, and type of visit with a copy of the WAMHC response. The Executive Assistant will maintain this file for at least five years.

WEST ALABAMA MENTAL HEALTH CENTER
Committee Assignments: FY 10-11

PIC
Patricia Perry Moore - Chair
Judy Walters
Pam Beck
Sandy Baker
Joyce Jackson
Buenia Fluker-Clark
LaShandra Prince
Rosanne Masse

MIC
Judy Walters – Chair
Pam Beck – Vice Chair
Joyce Jackson
LaShandra Prince
Buenia Fluker-Clark
Misty Samya
Chasity Williams
Rosanne Masse
Timeka Prince

Human Resources:
Sandy Baker – Chair
LaShandra Prince
Sandra Tubbs
Brenda Tucker
Marilyn Williams
Chasity Williams
Mattie Killings
Pearl Carlisle
Rosanne Masse

Health and Safety:
Rosanne Masse – Chair
Ellena Tabb
Valarie Walton
Brenda Johnson
Vanessa Moore
Jeanifer Monghan
Mattie Killings
Lisa Armstead
Makane Morrow
Trameika Green
Lori Walker
Christopher Quinney

Behavioral Review:
Timeka Prince – Chair
Buenia Clark – Vice Chair
Brenda Weaver - Family
Shenekia Kennedy
Martha McKnight
Debra Hildreth
Patricia Perry Moore-Advisor

Human Rights:
Trudy Cox– Provider
Martha McKnight-Education
Sharon Jay- DHR
Rosanne Masse – RN/PI
Chief Tommie Reese - Law Enforcement
Edna Cook – Consumer
Patricia Wright – community
Mattie Killings – ID Services
Stephanie Watson – MI Services
Atty. Woody Dinning – Advisor

Note: Patricia Perry Moore and Rosanne Masse serve as Ad Hoc member of each committee.

Revised: Jan-11

WEST ALABAMA MENTAL HEALTH CENTER
Committee Assignments: FY 09-10

PIC
Patricia Perry Moore - Chair
Judy Walters
Pam Beck
Sandy Baker
Joyce Jackson
Buenia Fluker-Clark
LaShandra Prince
Deborah Wilson
Rosanne Masse

Human Resources:
Sandy Baker – Chair
LaShandra Prince
Sandra Tubbs
Brenda Tucker
Marilyn Williams
Chasity Williams
Mattie Killings
Pearl Carlisle
Rosanne Masse

Behavioral Review:
Timeka Prince – Chair
Buenia Clark – Vice Chair
Brenda Weaver
DaVeeta Hines
Martha McKnight
Trudy Cox
Rosanne Masse
Patricia Perry Moore-Advisor

Note: Patricia Perry Moore and Rosanne Masse serve as Ad Hoc member of each committee.

MIC
Judy Walters – Chair
Pam Beck – Vice Chair
Sandra Tubbs
Joyce Jackson
Deborah Wilson
LaShandra Prince
Buenia Fluker-Clark
Misty Samya
Chasity Williams
Rosanne Masse

Health and Safety:
Sandy Baker – Chair
Ellena Tabb
Valarie Walton
Brenda Johnson
Vanessa Moore
Jeanifer Monghan
Mattie Killings
Lisa Armstead
Makane Morrow
Christopher Quinney
Trameika Green
Lori Walker
Rosanne Masse

Human Rights:
Viola Abraham– Chair
Timeka Prince
Martha McKnight-Community
Rhonda Lloyd-Community
Rosanne Masse (Co-Chair)
Atty. Woody Dinning - Advisor

Revised: ~~10-09~~ 4-10

Committee Assignments: FY 08-09

PIC
Patricia Perry Moore - Chair
Rita Harless – Vice Chair
Judy Walters
Pam Beck
Sandy Baker
Joyce Jackson
James Ward
Deborah Wilson
Rosanne Masse

MIC
Judy Walters – Chair
Timeka Prince
Sandra Tubbs
Joyce Jackson
Deborah Wilson
Pam Beck
Deborah Wilson
Rosanne Masse
LaShandra Prince
Buenia Clark

Human Resources
Sandy Baker – Chair
Shon Prince
Sandra Tubbs
Brenda Tucker
Marilyn Williams
Chasity Williams
Mattie Killings

Health and Safety
Sandy Baker – Chair
Ellena Tabb
Valarie Walton
Vanessa Giles
Brenda Johnson
Vanessa Moore
Jeanifer Monghan
Mattie Killings
Lisa Armstead
Teneshia Williams
Bryan Webb

Behavioral Review:
Patricia Perry Moore – Chair
Timeka Prince
Brenda Weaver
Buenia Clark
Martha McKnight
Trudy Cox

Human Rights
Rosanne Masse – Chair
Timeka Prince
Viola Abraham – Ceo – Chair
Martha McKnight
Rhonda Lloyd
Atty. Woody Dinning - Advisor

Ad-Hoc Committee - HR
Sandy Baker – Chair
Deborah Wilson
Joyce Jackson

Note: Patricia Perry Moore and Rita Harless are Ad Hoc members of each committee.

Revised: 1-21-09

Strategic Plan Overview
2009 - 2010

Performance Improvement Indicators

Performance Measure	Responsible Staff	Goal Attainment
PI #1		
1. Monitor staff productivity	PIC/Business/ Administration/Board	**100%**
2. Monitor paperwork of vans from 5309 & 5310 grant.	Residential Staff/ Business	**80%**
3. Reconciliation of clinical schedules with chart documentation	Review Staff/Billing HIM OM	**80%**
4. Monitor confidentiality of the information system	HIM/BM	**Yes**
5. Monitor MCD charts and billing sheets for corporate compliance	HIM/CD/BM	**Yes**
6. Develop and monitor the annual budget	BM/ED	**100%**
7. Monitor MCD and State billing for accuracy	BM/Billing	**100%**
8. Monitor Internal Compliance with records and MCD billing	BM/CD/HIM	**Yes**
9. Complete Audits and cost reports as required	BM/PD/ED/BOARD As needed	**Yes**
10. Monitor GL Posting of expenses in departments	PD/AP/ED	**Yes**
11. Quarterly Reports: -Grant Balances -Crisis Funding	BM/AP	**100%**
12. Complete and monitor expense and income reports for residential consumers	AP/BM/RSM/RA	**Yes**

Performance Measure	Responsible Staff	Goal Attainment
PI - #2		
1. Schedule Monitoring of charts in compliance with DHM and WAMH standards. Administrative, Clinical, Medical	Clinical Director Health Information Manager CQI Coordinator-ID	**100%**
2. Monitor effectiveness of BSP	ID Program Director Behavioral Review Committee(BRC)	**100%**
3. Clinical follow-up with high risk consumers.	C D Clinical Staff	**100%**
4. Ongoing monitoring of consumer caseloads	CD / HIM	**Yes**
5. Monitoring of all consumer lab work and compliance with reviews	Nursing Staff/ RN Supervisor	**85%**
6. Survey stakeholders in each program service area annually.	Executive Staff	**Yes**
7. Monitor NDP Compliance	RN Supervisor	**100%**
PI # 3		
1. Monitor contact with families of residential consumers	Residential Coordinator / Assigned staff	**Yes**
2.Monitor progress of IMR with consumers	IMR Practitioners	**100%**
3. Monitor progress toward BLS goals 90 days for revision or D/C	As assigned by C.D.	**Yes**
4. Nursing Homes monthly	Residential Coordinator	**Yes**
5. Monitor LOS for residential services	Residential Coordinator	**Yes**

Performance Measure	Responsible Staff	Goal Attainment
PI #4		
1. Monitor emergency drills monthly	Safety Officer HR Coordinator	100%
2. Monitor facility checklist monthly	Safety Officer Maintenance Coordinator HR Coordinator	100%
3. Monitor Training Plan Compliance	Supervisors / Staff HR Coordinator	100%
4. Monitor 90-day orientation compliance	HR Coordinator	80%
5. Staff supervision	Supervisors / HR Coordinator	100%
6. New Employee Orientation	Supervisors / HR Coordinator	95%
7. Monitor Staff Survey	HR Coordinator	Yes
PI #5		
1. Work with OM to maintain compliance with scheduling	OM	80%
2. Monitor confidentiality of the organizational information system	HIM BM	Yes
2. Monitor consumer Records for retention and purging process	HIM / OM/C D	80%
3. Monitor charts for Administrative Error rates	HIM	100%
4. Monitor MCD charts for corporate compliance	HIM CD BM	100%

Performance Measure	Responsible Staff	Goal Attainment
PI #6		
1. Monitor opportunities for family involvement in SA program	Program Director	**Need follow-up**
2. Evaluate outcome measures of Prevention Program	Prevention Coordinator / Program Director	**Need follow-up**
3. Monitor number of consumers served by Prevention each month	Prevention Coordinator/ Business/Billing	**Yes**
4. Monitor Environmental Campaigns monthly	ED/PD/Prevention Coordinator	**Yes**
5. Monitor meetings of Prevention Council	Prevention Coordinator/ Program Director	**Need follow-up**
PI #7		
1. Develop and monitor annual budget	ED / Business Manager/ Board	**Yes**
2. Monitor MCD & state pay billing for accuracy	AR Billing OM	**Yes**
3. Internal Compliance with records and MCD billing	Business Manager Clinical Director	**Yes**
4. Complete audits and cost reports as required	Business Manager CPA Administration	**Yes**
5. Quarterly reports on grant balances and crisis funding	Business Manager	**Yes**
6. Update D-Link	Billing	**Yes**

Strategic Plan Overview
2008-2009

Performance Improvement Indicators

Performance Measure	Responsible Staff	Goal Attainment
PI #1		
1. Monitor staff productivity	PIC/Business/ Administration/Board	**100%**
2. Monitor paperwork of vans from 5309 & 5310 grant.	Residential Staff/ Business	**100%**
3. Reconciliation of clinical schedules with chart documentation	Review Staff/Billing HIM OM	**80%**
4. Monitor confidentiality of the information system	HIM/BM	**Yes**
5. Monitor MCD charts and billing sheets for corporate compliance	HIM/CD/BM	**Yes**
6. Develop and monitor the annual budget	BM/ED	**100%**
7. Monitor MCD and State billing for accuracy	BM/Billing	**100%**
8. Monitor Internal Compliance with records and MCD billing	BM/CD/HIM	**Yes**
9. Complete Audits and cost reports as required	BM/PD/ED/BOARD As needed	**Yes**
10. Monitor GL Posting of expenses in departments	PD/AP/ED	**Yes**
11. Quarterly Reports: -Grant Balances -Crisis Funding	BM/AP	**90%**
12. Complete and monitor expense and income reports for residential consumers	AP/BM/RSM/RA	**Yes**

Performance Measure	Responsible Staff	Goal Attainment
PI - #2		
1. Schedule Monitoring of charts in compliance with DHM and WAMH standards. Administrative, Clinical, Medical	Clinical Director Health Information Manager CQI Coordinator-ID	**100%**
2. Monitor effectiveness of BSP	ID Program Director Behavioral Review Committee(BRC)	**100%**
3. Clinical follow-up with high risk consumers.	C D P. Plotkins Clinical Staff	**100%**
4. Ongoing monitoring of consumer caseloads	CD / HIM	**Yes**
5. Monitoring of all consumer lab work and compliance with reviews	Nursing Staff/ RN Supervisor	**80%**
6. Survey stakeholders in each program service area annually.	Executive Staff	**Yes**
7. Monitor NDP Compliance	RN Supervisor	**100%**
PI # 3		
1. Monitor contact with families of residential consumers	Residential Coor. / Assigned staff	**Yes**
2.Monitor progress of IMR with consumers	IMR Practitioners	**100%**
3. Monitor progress toward BLS goals 90 days for revision or D/C	As assigned by C.D.	**Yes**
4. Nursing Homes monthly	Residential Coordinator	**Yes**
5. Monitor LOS for residential services	Residential Coordinator	**Yes**

Performance Measure	Responsible Staff	Goal Attainment
PI #4		
1. Monitor emergency drills monthly	Safety Officer HR Coordinator	**100%**
2. Monitor facility checklist monthly	Safety Officer Maintenance Coordinator HR Coordinator	**100%**
3. Monitor Training Plan Compliance	Supervisors / Staff HR Coordinator	**100%**
4. Monitor 90-day orientation compliance	HR Coordinator	**100%**
5. Staff supervision	Supervisors / HR Coordinator	**100%**
6. New Employee Orientation	Supervisors / HR Coordinator	**95%**
7. Monitor Staff Survey	HR Coordinator	**Yes**
PI #5		
1. Work with OM to maintain compliance with scheduling	OM	**80%**
2. Monitor confidentiality of the organizational information system	HIM BM	**Yes**
2. Monitor consumer Records for retention and purging process	HIM / OM/C D	**80%**
3. Monitor charts for Administrative Error rates	HIM	**100%**
4. Monitor MCD charts for corporate compliance	HIM CD BM	**100%**

Performance Measure	Responsible Staff	Goal Attainment
PI #6		
1. Monitor opportunities for family involvement in SA program	Program Director	**Need follow-up on family participation**
2. Evaluate outcome measures of Prevention Program	Prevention Coordinator / Program Director	**Need follow-up**
3. Monitor number of consumers served by Prevention each month	Prevention Coordinator/ Business/Billing	**Yes**
4. Monitor Environmental Campaigns monthly	ED/PD/Prevention Coordinator	**Yes**
5. Monitor meetings of Prevention Council	Prevention Coordinator/ Program Director	**Need follow-up**
PI #7		
1. Develop and monitor annual budget	ED / Business Manager/ Board	**Yes**
2. Monitor MCD & state pay billing for accuracy	AR Billing OM	**Yes**
3. Internal Compliance with records and MCD billing	Business Manager Clinical Director	**Yes**
4. Complete audits and cost reports as required	Business Manager CPA Administration	**Yes**
5. Quarterly reports on grant balances and crisis funding	Business Manager	**Yes**
6. Update D-Link	Billing	**Yes**